

BEFORE THE  
OFFICE OF ADMINISTRATIVE HEARINGS  
STATE OF CALIFORNIA

In the Matter of:

OAH No. L 2005110100

LUKE P.,

Claimant,

and

REGIONAL CENTER OF ORANGE  
COUNTY,

Service Agency.

**DECISION**

On July 11, 13, September 12, 14, October 19, 24, November 7 and 28, and December 8, 2006, in Santa Ana, California, Alan S. Meth, Administrative Law Judge, State of California, Office of Administrative Hearings, heard this matter, which was consolidated for hearing with the matter of Shane P., OAH No. L2005110099.

Shelli J. Lewis, Attorney at Law, represented claimant.

Mary Kavli, Fair Hearing Officer, represented the service agency.

The matter was submitted on December 8, 2006.

**ISSUE**

Whether claimant is eligible for regional center services with a diagnosis of autism.

**FACTUAL FINDINGS**

1. Claimant is five years old and lives with his parents and two brothers in Mission Viejo, California. His mother made a self-referral to the service agency on October 2, 2002, when he was 17½ months old but since he was born prematurely, his adjusted age was 15½ months. The service agency found he was eligible for services in October 2002, and he received early intervention services until April 2004, when he turned three years of age. At that time, he was found not eligible for Lanterman Services. The family was notified of this decision and did not appeal it.

Claimant's mother contacted the service agency on July 13, 2005 to have claimant reassessed for service agency eligibility and general services. She informed the service agency that claimant had received a diagnosis of autism from Betty Bostani, Ph.D. in December 2004 and autistic spectrum disorder from Joseph Donnelly, M.D. in June 2005. After performing an assessment, the service agency determined claimant did not meet the eligibility requirements of Welfare and Institutions Code section 4512, subdivision (a). In particular, the service agency determined claimant did not have substantial handicaps in three or more of the specified areas as required by Welfare and Institutions Code section 4512, and informed claimant's mother of this determination by letter dated October 7, 2005.

It is this decision which is the basis of this appeal.

### Reports

2. Marilyne Thompson is a service coordinator for the service agency in the Intake and Assessment Unit. She performed an intake assessment on August 1, 2005 and wrote a Social Assessment. She met claimant and his mother in the family home and found that claimant was receiving therapy from a therapist from the Center for Autism and Related Disorders, Inc. (CARD). She noted claimant made intermittent eye contact with her and the therapist and he spoke in sentences with fair-good articulation and intelligibility. She noted his receptive language appeared good and observed him answer questions from the therapist appropriately. She found claimant attended to all tasks given to him despite potential distractions and played with his brother in what appeared to her to be creative play. Ms. Thompson reported that claimant attended Grace Preschool and that Saddleback Valley Unified School District (District) partially funded the placement.

Ms. Thompson considered claimant's current functioning. Regarding his motor ability, she reported that claimant was ambulatory with no gait or balance disturbance observed. Claimant was able to run and hop, could extend all his extremities, did not pedal a tricycle or maintain his balance on one foot, according to his mother. She reported he had fine motor deficits such as difficulty picking up small objects with his thumb and forefinger, although she observed him holding a pencil in the appropriate grasp without assistance.

Regarding self-care, Ms. Thompson reported that claimant was able to eat with a spoon and fork although he preferred to finger feed; there was some spillage with utensils due to his difficulty in holding the tableware; he could put on his shirt, shorts, underwear, and socks; he could not put on his shoes and could not button, tie, or zip his clothing; he used the toilet independently; he needed assistance with showering, brushing his teeth, and washing his hands; he will attempt all tasks but needs assistance to complete them; and he will pick up toys with prompts.

As for his social/ behavioral/emotional functioning, Ms. Thompson reported claimant had received 20 hours weekly of CARD in-home services since February 2005; he generally ignored new persons and others had to initiate interactions and if they did, he would engage; he avoided eye gaze with strangers but made good eye contact with his family members; he

preferred to play alone with his twin brother and would actively avoid other children; his play was repetitive, scripted, and generally parallel; and he could play interactively with assistance and direction from others. His mother told Ms. Thompson that claimant was more heightened of the twins, he needed deep pressure to calm and regulate his behavior, the parents had to initiate affection although he would receive it, he was clingy at times and failed to respect personal boundaries, he would “get up in (his mother’s) face,” he did participate in a play group but he shared friends with his brother at school, and when they played together, they did not initiate interactions with other students. Claimant’s mother described other aspects of his behavior, and frequently compared him with his brother. She did not describe any repetitive, aggressive, or self-injurious behaviors, although claimant was frequently resistant when getting ready for school. She reported claimant’s interests were limited to Super Heroes and he was a picky eater. According to his mother, claimant’s speech was scripted and perseverative mostly about Super Heroes, with only 30 percent original and appropriate, his speech was fragmented, and he could not express concepts, he did not ask questions, and had difficulty with reciprocal conversation. Claimant understood basic gestures and facial expressions but not body language and social skills. She did not feel claimant’s safety awareness was age appropriate and he had to be closely monitored at all times.

Ms. Thompson observed claimant make intermittent eye contact, he spoke in sentences with fair to good articulation and intelligibility, his receptive language appeared to be good, he answered questions appropriately, he performed the tasks required of him by his therapist, he frequently smiled when he completed a task, he played with shaving cream and seemed to be enjoying himself, he ran awkwardly, and he and his brother engaged in interactive play after the therapist left.

Regarding cognition, Ms. Thompson reported the District assessed claimant and obtained a mental development score within the average range. On the Wechsler Preschool and Primary Scales of Intelligence (WPPSI-R) performed by Dr. Bostani in 2004, claimant achieved a PIQ OF 73, VIQ of 90, and a FSIQ of 80, and that claimant was in the below average range of overall intellectual functioning. She noted results on other tests as well.

As for communication, Ms. Thompson reported the District’s assessment for special education, and his speech and language was within the average range. Dr. Bostani tested his language using the Preschool Language Scale-4<sup>th</sup> Edition, and found his scores were average. Ms. Thompson found claimant’s eye contact varied with the person and the environment, he spoke in sentences with fair-good articulation, his vocabulary was average, he engaged in scripted and perseverative speech, he understood simple conversations, and he could follow a two step command.

3. On January 29, 2004, Susanne Tasin, M.S., the case supervisor, and Doreen Granpeesheh, Ph.D., Clinical Director, wrote a regional center initial report. They noted claimant then attended Rainbow Kids which provided one hour per week of physical and speech therapy. They found he showed delays in language development, gross motor development, social development, and self-help skills. They indicated claimant displayed maladaptive behaviors that required behavior intervention and parent training. They

recommended claimant continue to receive speech and occupational therapy and social groups. The further recommended claimant begin receiving six hours of initial parent training and two hours per month of supervision after the initial training, and that a qualified ABA consultant provide training to the parents to implement and monitor a behavior management plan to increase appropriate behaviors and decrease inappropriate behaviors. The indicated the program would continually evaluate his progress. Finally, they recommended that claimant be assessed yearly.

4. Therapists from Rainbow Kids wrote an Infant-Toddler Discharge Report dated March 26, 2004 summarizing claimant's testing and progress while he attended the program. He was then 35 months old. Their diagnosis was developmental delay. Claimant had been receiving two hours weekly of speech therapy for one year and had made significant gains in the areas of language and functional communication behavior.

Testing showed claimant was at the 30 to 33 month level in cognition according to the Hawaii Early Learning Profile, and he had made considerable progress since the last report of October 2003. The Hawaii profile also showed him to be in the same age range in social-emotional development. In receptive language, claimant was at the 33 to 35 month level based upon the Preschool Language Scale-3. The therapists determined claimant was at the 34 to 35 month level in expressive language, but his fine and gross motor skills were at the 28-month level. They determined his self-help skills were at the 24-month level, which represented a 30 percent delay. They determined he demonstrated typical performance in the areas of general, visual, tactile, vestibular, and oral sensory processing, but atypical performance in auditory processing. They indicated he frequently ignores people when they are talking to him, he sometimes takes a long time to respond to his name, his eye contact is improving, but he is easily distracted and demonstrates a decreased attention span.

The therapists recommended claimant be discharged from therapy with Rainbow Kids because he was about to turn three years of age and that he continue socialization with peers in a regular preschool program. They pointed out his gross motor skills had improved over the previous few months but still showed a 20 percent delay, as did his fine motor skills which had improved only slightly. They believed claimant would benefit from a therapy program that continued to address his fine and gross motor skills.

5. The Saddleback Valley Unified School District tested claimant on March 5 and 29, 2004 and wrote a Multidisciplinary Assessment Documentation dated April 23, 2004.

a. Claimant was referred for special education by the service agency. Claimant was observed during speech and language therapy at Rainbow Kids. The District's assessment included administration of a number of tests: on the Bayley Scales of Infant Development-II, claimant's scores were within normal limits; on the Autism Diagnostic Observation Schedule (ADOS), claimant's scores did not meet the criteria for an ADOS classification of autism or autism spectrum disorder; on the Child Development Inventory (CDI), which is based on parental responses, it appeared claimant did not talk well for his age, his speech is difficult to understand, he is dependent, clingy, and becomes upset when

separating, he cannot sit still, he is demanding and strong-willed, and he is disobedient; and on the Preschool Language Scale-4, his scores were in the average range.

The District evaluators concluded that claimant did not meet the educational criteria for autism, based upon standardized assessment, observation, review of records, and parent report. They indicated the results of the evaluation suggested an overall developmental functioning between 18 months and 33 months, with cognitive skills within normal limits. They indicated claimant presented with overall receptive and expressive language functioning at the 33 months level with some language skills in the 42-47 month range and some expressive skills in the 36-41 month range. They noted production of speech phonemes for isolated words and sentences was within normal limits but articulation became imprecise in conversation and impacted intelligibility. They recommended special education with speech and language impairment as the eligible condition. As the functional description of the handicapping condition, they described variable, imprecise production of speech phonemes within conversational speech and medical diagnosis of history of cerebral dysfunction and global developmental delay.

b. The District also performed a school-based occupational therapy assessment on March 15, 2004. Claimant's mother's concern was with claimant's fine motor skills, balance, and weakness. The assessment took an hour and included standardized testing, a questionnaire, clinical observation, parent report, and chart review. The District found that claimant demonstrated adequate postural stability, muscle tone, and strength to sustain an upright position in a chair and access his school environment. Some proprioceptive seeking behaviors were noted but claimant was able to maneuver throughout the clinic environment without colliding with people or objects. Mildly reduced static and dynamic balance were noted and complex two-step sequences were challenging. His fine motor skills were in the 12<sup>th</sup> percentile and he used an immature grasp on a spoon and a marker. Claimant did not exhibit visual motor skills to consistently imitate vertical and horizontal strokes. It was believed his current areas of delay might impact his overall performance in the classroom setting.

6. The District asked Paul Alan Does, Ph.D. and a licensed psychologist, to evaluate claimant to provide opinions and recommendations regarding the nature of his challenging behavior. He visited the home on October 29 and November 17, 2004, visited his preschool class on November 17, 2004, and conducted a record review. He interviewed claimant's mother and summarized the information she reported to him. He also described his observations in school and at home.

Based upon the information provided to him and his observations of claimant, Dr. Does concluded claimant exhibited some challenging behaviors, primarily in the form of noncompliance and tantrum behaviors such as screaming, crying, and falling to the ground, and they could occur several times a day. He noted they occurred when claimant was at home or with his mother in the community, and they functioned as a means to escape non-preferred demands and to gain maternal attention. Dr. Does reviewed reports from CARD which indicated claimant exhibited noncompliance, tantrums, and aggression. Dr. Does, however, observed only mild noncompliant behavior. Other information suggested to him

that claimant's noncompliance might be significant enough to create some difficulties at home, but not in clinical or educational settings.

Dr. Dores agreed with CARD that the primary focus of intervention should be on preventative strategies to organize the home environment so as to reduce the difficulties which arose during the morning routine and other hectic transitions. He felt the issue in the home was the ability of claimant's parents to implement strategies correctly and consistently, and he recommended that any behavioral consultation be focused on assisting the parents. He believed consultation should be delivered on a short-term basis.

7. Pediatric speech and physical therapists at Rainbow Kids Achievement Center prepared an infant-toddler discharge report dated March 26, 2004. They reported claimant had made "significant gains" in the areas of language and functional communication during the previous year. They placed his cognitive level at 30-33 months and noted he had made considerable progress since October 2003. They indicated his receptive language was at the 33-35 month level and his expressive language was at the 34-35 month level. They reported his gross motor level was at 28 months and noted he had difficulty walking on a line and on a balance beam. His fine motor skills were also at the 28-month level. His social-emotional scores placed him at the 30-33 month level and his self-help/feeding scores were at the 24-month level. This represented a 30 percent delay. In the sensory/regulatory area, claimant demonstrated typical performance in the areas of general, visual, tactile, vestibular, and oral sensory processing, but demonstrated atypical performance in auditory processing. They reported he frequently ignored people when they were talking to him and sometimes took a long time to respond to his name. He did demonstrate improved eye contact but he was easily distracted and demonstrated a decreased attention span needing frequent redirection during therapy sessions.

A review of his previous goals showed most had been met.

8. On May 5, 2004, Miche' Almeida, M.S., a speech and language pathologist, wrote a consultation summary following a consultation the previous day prompted by claimant's mother's concern regarding his speech development and oral motor skills. Ms. Almeida judged claimant's articulation skills to be approximately 85 percent intelligible but within conversational speech, his speech clarity decreased as the length of his utterance increased. She believed he demonstrated mild characteristics of motor planning difficulties. He also demonstrated mild difficulty with oral motor tasks.

Ms. Almeida concluded claimant presented with age-appropriate expressive language skills and functional oral motor strength, range of motion and function for most oral motor tasks, but he exhibited mild oral motor planning difficulties characterized by vowel distortions and imprecise consonants in nonsense syllable tasks and in connected speech, and this impacted the clarity of his speech at the sentence level. She recommended one hour of oral motor treatment one time per week for three to six months.

9. On May 9, 2005, Beth Ballinger, O.D., wrote a letter to claimant's parents following an examination. She found he demonstrated oral motor apraxia, dysarthria/slurred

speech, fine motor dysfunction in areas other than oral motor integrity, intermittent left eye exotropia, and 15 to 20 prism diopters of left exotropia depending on visual fatigue and duration of the visual demand. She recommended orthoptic therapy to remediate his exotropic visual condition which negatively impacted his visual development and daily living skills. The therapy was to consist of two hours per week to address his fine visual-motor binocular dysfunction. She indicated without proper therapy, claimant would have difficulty in visual acquisitions for clear single binocular vision which will interfere with visually directed motor demands for movement and he would not outgrow the dysfunction. She felt there was an excellent prognosis with immediate attention.

Dr. Ballinger began treating claimant in January 2006, and wrote a report of her assessment of him on February 28, 2006. She recounted the therapy claimant had received and the diagnoses, including autism and neuro-developmental dysfunction, oral-motor dyspraxia, dysarthria/slurred speech, convergence insufficiency at near, and fusion dysfunctioning.

Dr. Ballinger performed a visual examination. She found his visual acuity was 20/20 at distance and 20/25 at near point; he was slightly farsighted and had a small amount of astigmatism. She indicated glasses had not been prescribed until a course in vision therapy designed to improve visual-motor competency.

As far as eye movement, Dr. Ballinger determined claimant followed a target by moving his head instead of just his eyes and had difficulty differentiating fine motor eye movements from larger motor head movements. She noted he might overshoot his target when he moved his head, and peripheral distracters interfered with his ability to accurately monitor and predict where his eyes must move to when looking at visual targets. She felt this would impact his reading accuracy, negatively impact his ability to rapidly process information and his comprehension and require him to take more time to process information, interfere with other movements, provide him inaccurate information, and cause fatigue.

Dr. Ballinger found claimant demonstrated significant focusing instability. She felt this was a major contributing factor that would interfere in proper visual uptake over time and it already contributed to fragile sustainable visual attentional abilities. She also found he demonstrated significant eye teaming dysfluency, with intermittent left eye exotropia and near point and a compensatory head turn to his left to help block off his left eye and favor his right eye. She noted he also closed or squinted his left eye with seeing double as an avoidance strategy. When claimant tired of doing this, he visually disengaged from the task. She believed this problem had been present a long time and was a significant contributing factor to why he visually disengaged from near point tasks and avoided sustained visual demands which overwhelmed him. She pointed out claimant also had a history of gross and fine motor deficits as well as deficits in bilateral coordination, and visual coordination was an aspect of his global motor difficulties.

Dr. Ballinger administered tests designed to measure claimant's visual information processing. Claimant's scores were average in the areas of visual discrimination, visual

memory, visual figure ground, and visual closure, but significantly below average in visual spatial relationships, form constancy, and sequential memory. Dr. Ballinger noted that with visual discrimination, claimant was able to achieve an average score by identifying objects verbally, but this strategy fell apart when a sequence of items was presented.

In summary, Dr. Ballinger concluded claimant demonstrated difficulty maintaining accurate and efficient eye movement free of head movement, focusing accuracy sustained over time, eye teaming integrity at near point with sustainable duration, visual attentional maintenance, visual-motor integration, visual spatial relationships, visual form constancy, visual sequential memory, and possibly auditory sequential memory integrity. She believed these difficulties could have a profound impact on visual demands as they become more complex and sophisticated, and negatively impact his visual attention and processing speed, thereby negatively affecting school functioning. She believed many of the important foundation skills could be redeveloped and interwoven into his life, thereby expanding his opportunity for more educational success. She gave a list of recommendations including Optometric Vision Therapy and those to be used in an educational setting such as having him sit in the center of the front row in class, working in a quiet environment without distractions, allowing him more time, and so forth.

10. On June 25, 2004, Joanne G. Hein, M.S., a speech-language pathologist, wrote an evaluation report relating to claimant's language functioning. She reviewed prior reports and administered a series of tests. She found claimant presented with a varied profile of language skills, from the high-average range for his age on one measure to the impaired range on other tasks. She reported that in general, claimant functioned within an age-appropriate range on receptive language skills, with the exception of his response to the receptive vocabulary tests, and many of his expressive language skills were within the average range. However, she found a definite weakness in his ability to include all needed parts of language to express his ideas clearly. She concluded he had a mild to moderate expressive language disorder and was at risk for a receptive language disorder, secondary to reduced and selective attention for linguistic information. She also concluded claimant presented with a mild to moderate articulation disorder secondary to reduced tongue mobility, difficulties with saliva control, and some oral-motor sequencing difficulties.

Ms. Hein observed no atypical behaviors attributable to autism, and he related well to her and was highly responsive. She noted he projected his thoughts beyond the concrete and to take the perspective of another person at times during play. Thus, she believed he had an expressive language impairment and articulation disorder, with difficulties with social language, but because of his family history, he remained at-risk for functioning along the autism spectrum. Ms. Hein believed claimant's prognosis was excellent for increasing receptive and expressive language, articulation, and social communications to age-level functioning following a course of therapeutic intervention. She recommended one to two hours per week of therapy in the area of speech-language pathology for one to two years, plus consultation among treating professionals and the family.

On March 10, 2006, Ms. Hein performed a second evaluation and wrote a report dated April 10, 2006. The evaluation was designed to determine the progress claimant had



made since the initial evaluation and to make recommendations for further treatment. She administered the Clinical Evaluation of Language Fundamentals-Preschool-Second Edition (CELF-P2P) to obtain a better understanding of claimant's receptive and expressive language functioning. Claimant's scores were in the average range for core language (100), receptive language (101), expressive language (96), language content (102), and language structure (96). He scored very low on the criterion score subtests. On the Goldman-Fristoe Test of Articulation-2, claimant's score of 107 was in the average range.

Ms. Hein reported claimant presented with greatly improved receptive and expressive language skills overall compared to the 2004 evaluation. She indicated his particular weakness involved social language skills and those skills needed to access an academic curriculum. She noted he had made excellent gains in articulation and language since the first evaluation but his multiple diagnoses, particularly the autism spectrum disorder, kept him at risk for ongoing receptive and expressive language deficits, imprecise articulation in connected speech, and social-pragmatic dysfunction. She pointed out that despite many test scores in the average range for his age, several specific observations of his performance during the re-evaluation were red flags for future difficulties, particularly if he were required to perform with increasing independence in an educational environment. She anticipated that as he moved through elementary school, he would be expected to have increased difficulty following directions, interpreting increasingly complex concepts, and expressing what he knows in an organized and intelligent manner, and that intensive programming was needed to continue to teach claimant the skills he needed to offset his areas of risk and relative weakness.

Ms. Hein felt claimant's prognosis was excellent for increasing receptive and expressive language, articulation, and social communications to age-level functioning, following a continued team-oriented course of therapeutic intervention. She estimated one to two hours per week of direct therapeutic intervention in the area of speech-language pathology, and one to two hours per month of consultation among treating professionals and the family.

11. On March 30, 2004, Orange County Therapy Services performed a physical therapy evaluation on claimant. His scores on several tests showed he was functioning in the 31 to 41 month range in gross motor development skill level, he could climb stairs and ramps, he could run satisfactorily, and he was meeting his gross motor milestones. Therefore, educationally based physical therapy was not recommended.

12. On May 20 and June 9, 2006, Elaine S. Ito, Ph.D., a licensed psychologist, performed a psychological evaluation of claimant to assess his current functioning and assist in the determination of his eligibility for regional center services. She administered a series of standardized tests, reviewed previous evaluations, and observed his behavior. The evaluation took place in claimant's home, and his mother provided the relevant history.

In her report under the heading of "Behavioral Observations," Dr. Ito indicated claimant smiled and reciprocated her greeting when she opened the door for her. Claimant introduced himself to her and called for his mother at Dr. Ito's request. Dr. Ito observed

claimant get into an argument with his brother when they were eating breakfast and she noted he exhibited appropriate eye contact. While he was taking the Stanford-Binet test, claimant frequently joked about various test stimuli, but his joking was also disruptive. Dr. Ito was able to redirect him back on task. At one point, the noise of a lawnmower bothered claimant and interrupted him, but he returned to task when the noise was eliminated. Claimant became distracted when his brother fell, but he returned to the testing, and again when he heard an ice cream truck. At the end of the testing, claimant went to the bathroom, and his mother told Dr. Ito he was able to take care of his toileting needs, but needed some help. During the testing, claimant became increasingly frustrated as test items became more difficult, and began to whine, asking when they would be done. With encouragement, claimant completed the testing. Dr. Ito concluded that because claimant was able to focus, with constant redirection, the test results were probably a good estimate of his current overall cognitive functioning, but she cautioned that specific scores may not be predictive of his long-term functioning due to his young age.

On the Stanford-Binet, claimant's scored 96 on the verbal and nonverbal tests, and his full scale IQ was also 96. His scaled scores on the subtests ranged from seven to twelve (the mean is ten). His scores on fluid reasoning, knowledge, quantitative reasoning, visual-spatial processing, and working memory ranged from 91 to 106. Claimant's cognitive abilities therefore fell within the average range. There was some scatter in his performance sufficient to suggest possible strengths and weaknesses. On the Test of Visual-Motor Integration (VMI), claimant had a standard score of 80 placing him in the ninth percentile and with an age equivalent of three years, ten months. On the Adaptive Behavior-Assessment System, Second Edition (ABAS), a test which used information provided by claimant's mother, his general adaptive composite was 57, his conceptual composite score was 61, his social composite score was 54, and his practical score was 54. These scores placed claimant in the mildly to moderately delayed ranges and at or below one percent of his age peers. Dr. Ito reported the considerable information claimant's mother provided which supported these scores.

Dr. Ito interpreted the VMI as showing possible weakness. She noted his pencil grip was awkward, and his grip was weak. Claimant could not draw a square, a diagonal line, or a triangle, and his lines were light and wavy. She explained that his delayed drawing skills were not unexpected given his difficulties with motor planning and visual perceptual deficits.

Based on claimant's scores on the Stanford-Binet test, Dr. Ito ruled out mental retardation, but she interpreted claimant's scores on the ABAS as indicating there may be factors that are interfering with his reaching his potential in terms of functioning. She indicated claimant's behaviors during the evaluation might provide clues to identify the underlying factors, including significant attention issues, seeking out sensory input, sensitivity to outside noises, global motor planning issues, clumsiness, struggling with visual perceptual skills, and processing difficulties.

In Dr. Ito's view, claimant would benefit from interventions to address the individual behavioral concerns, such as individualized attention to help him achieve his academic goals despite his attention issues and difficulty with auditory information, and continued

occupational therapy to address the fine motor difficulties, motor planning issues, and sensory integration deficits. She could not determine if his current delays in adaptive functioning were suggestive of a lifelong disability, and she hoped that with his cognitive strengths, his daily functioning would improve. Dr. Ito believed claimant's progress should be closely monitored over time. She felt many of his deficits could be explained by his diagnosis of autism. She concluded he presented with a very complex diagnostic picture resulting in complex intervention needs. She recommended continued services to facilitate his pragmatic language and conversational skills, continued occupational therapy, continued participation in a classroom setting that provides individualized attention, and verbal prompting.

13. Dr. Joseph Donnelly is a pediatrician at the UCI Medical Center in Irvine.

a. The first letter he wrote which appears in the record is dated March 14, 2003, when claimant was 23 months old. He noted claimant was born prematurely and experienced medical problems shortly after his birth. Dr. Donnelly indicated claimant had delays in his development from the beginning. His neurological examination showed claimant was awake, alert, made eye contact, explored the room, and looked at lots of toys. He briefly played with the toys, pointed to objects, he made sounds indicating he wanted some hats hanging on a wall, he laughed, smiled and enjoyed some games, and he followed the doctor's hand when he pointed, followed commands and carried out suggestions. Claimant said a few words but did not always understand what the doctor said and could not answer questions. Dr. Donnelly found claimant's station and gait were normal, a cranial nerve examination was unremarkable, and other tests were normal. He indicated claimant did not meet the DSM-IV criteria for autistic disorder.

Among the impressions Dr. Donnelly listed was cerebral dysfunction, early onset, nonprogressive, manifested by global developmental delays, especially involving language, but with relatively good social interaction, requiring intensive intervention. He felt claimant was at risk for autism but at the time of the examination he was not in the autistic spectrum but was active, inattentive, and was having trouble focusing. He observed it was not possible to know whether claimant could have a disorder at the mild end of the autistic spectrum and believed claimant needed to be followed and intensive intervention provided.

b. Three months later, on June 24, 2003, Dr. Donnelly wrote a letter describing his neurological examination. He indicated that since he last saw claimant, claimant had made "a lot of gains," including using about 25 words and imitating more, using two-word phrases, following some one-step commands, and pointing to body parts. He believed claimant's receptive language was about four months behind and his expressive language about six to eight months behind. He noted claimant was receiving early intervention through Rainbow Kids and an hour of physical therapy and an hour of individual speech and language plus an hour of peer group speech and language. He called claimant's behavior "a handful."

Dr. Donnelly indicated claimant had global delays involving expressive language, but was social and interactive, and did not meet DSM-IV criteria for autistic disorder. He recommended continued aggressive early intervention.

c. Dr. Donnelly saw claimant again five months later and wrote a letter dated November 4, 2003. He summarized information he received from claimant's mother and from Rainbow Kids. He noted claimant was currently making progress with early intervention but sensory was still felt to be somewhat atypical. He listed claimant's estimated age equivalents in a number of areas, and all were delayed. Dr. Donnelly's impression was that claimant was making progress but he seemed aloof at the time of the examination. He believed claimant had significant delays and yet was making good progress, but he continued to believe claimant was not within the autism spectrum. He believed claimant could use more language intervention and his mother could use assistance with behavioral intervention.

d. Dr. Donnelly did not see claimant again until June 8, 2005, when claimant was four. He noted claimant "was making a lot of developmental progress, but there has been persistent though variable concerns." He noted claimant was evaluated by Dr. Betty Bostani, a psychologist, in the fall of 2004 who felt claimant met the criteria for autistic disorder. He reported that claimant was then in a CARD 20-hour per week behavioral intervention program and was receiving speech and language, with occupational therapy planned.

Dr. Donnelly felt claimant continued to make overall progress, and yet, over time, has shown qualitative problems in social interaction and communication which placed him on the autism spectrum "based on the information I have to date and exam/observation." His recommendations included continued special education programming and behavioral intervention, speech and language, and OT.

e. Dr. Donnelly saw claimant on September 6, 2006. He noted that in the interim, claimant had continued to make progress in all areas with an intensive educational program. He indicated that a report to him offered the view that claimant was not ready for kindergarten due to problems with visual, motor, and fine motor skills as well as pre-academic skills, and he needed a multi-sensory approach, but he had not lost any acquired skills. Dr. Donnelly reviewed records and performed a physical examination. His impression was that claimant had early global delays but had made continued and excellent progress, but he had weaknesses which were well clarified by Dr. Ito's report. Dr. Donnelly indicated claimant had weaknesses in a number of developmental areas which taken together certainly impacted his functioning. He wrote that it sounded as if he was having significant learning difficulty despite his intelligence and problems with handwriting which suggested an evolving learning disability, motor output disorder, and even mild attention deficit hyperactivity disorder in the context of a mild and also evolving autism spectrum disorder.

14. Dr. Betty Bostani is a licensed clinical psychologist.

a. She assessed claimant on October 6 and 25, 2004, and observed him at home on December 8, 2004. She wrote a psychological assessment report after the observation. Dr. Bostani administered a number of psychological reports, but did not review any other reports or interview anyone other than claimant's parents.

Dr. Bostani administered the WPPSI-R. Claimant achieved a performance IQ of 73, a verbal IQ of 90, and a full scale IQ of 80, which placed him in the below average range in overall intellectual functioning. On the Leiter International Performance Scale--Revised, a test of intellectual ability, memory, and attention, claimant scored in the average range in visualization, reasoning, and associated pairs, and in the poor range in forward memory.

Dr. Bostani administered the Preschool Language Scale—4<sup>th</sup> Edition, which measures receptive and expressive language skills. Claimant's score of 99 in auditory comprehension placed him at the age equivalent of three years, three months, and his score of 114 in expressive communication placed him at the age equivalent of three years, eleven months. His total language score of 107 placed him the age equivalent of three years, six months.

On the Behavior Rating Inventory of Executive Function—Preschool Version (BRIEF-P), a questionnaire for parents and teachers for the assessment of executive function behaviors in the home and preschool environments, claimant's scores on the scales of Inhibit, Emotional Memory, Inhibitory Self-Control Index, and Flexibility Index placed him in the area of potentially clinically significant dysfunction. He scored in the average range in Shift, working Memory, Plan/Organize, and emergent Metacognition Index. His overall global executive composite score placed him in the area of potentially clinically significant dysfunction.

Dr. Bostani used the Vineland Adaptive Behavior Scales which is a structured interview administered to parents to measure claimant's adaptive behavior in the domains of communication, daily living skills, socialization, and motor skills. Claimant's scores were adequate in communication, moderately low in daily living skills and socialization, and low in motor skills. His composite was moderately low.

Dr. Bostani used the Clinical Autism Rating Scale (CARS) to assess whether claimant was autistic. Claimant's score of 32, according to Dr. Bostani, met the diagnostic criteria for autistic disorder in the DSM-IV. She placed him in the mild range.

Dr. Bostani concluded that claimant required structure, with clear and consistent expectations and consequences, and if given appropriate intervention, is a child with considerable potential to make progress in all of areas of deficit, and function independently in the community. She recommended he receive an in-home behavioral intervention in the form of ABA to include discrete trial teaching. She recommended participation in a typical classroom, and other interventions as well.

b. Dr. Bostani performed a second assessment of claimant in April and May 2006. This time, she reviewed other, recent reports, and administered a number of tests. On the WPPSI-III, claimant's scores increased, with him achieving of full scale IQ of 103, a performance IQ of 110, and a verbal IQ of 102. However, his processing speed was below average at 88. Dr. Bostani observed that claimant evidenced significant progress in all areas of intellectual functioning relative to his previous assessment. However, on the BRIEF—P, claimant's scores remained low, with only Inhibit and Shift in the average range, and all the other scores as well as the global executive composite were well below average. Dr. Bostani noted the executive functions increase proportionately with age, and therefore claimant continued to require development in the areas of inhibitory self-control, flexibility, and emergent metacognition.

Dr. Bostani administered the Test of Pragmatic Language (TOPL) to assess the pragmatic or social dimension of language. Claimant scored in the average range with an age equivalent of six years. Claimant's scores on the Leiter—R did not change in the areas of associated pairs and forward memory. Other areas were not tested. On the Vineland, with claimant's mother as the informant, claimant's scores were mostly in the moderately low area.

Dr. Bostani described her observation of claimant at school: he demonstrated appropriate eye contact, responded to group questions, and maintained focus towards his teacher. He had difficulty with touching his elbows to his opposite knees, and did not use his arms when he did jumping jacks. He responded well to a conflict situation between peers. He stood alone for several minutes until prompted by a teacher to play with someone or something, and he chose to play basketball alone until prompted to play with someone. Claimant interacted with his brother until he became upset with him, and stood alone again. He imitated the actions of others while singing songs about 70 percent of the time. He needed prompting to participate in prayer or answering questions, and did not socialize much. He was the first to ask to be excused and then went off to play by himself. Claimant's play was isolated with minimal dialogue with figurines. Claimant was instructed to write his name on the back of an arts and crafts project, but he only wrote the letter L, and other written letters were not legible.

According to claimant's teacher, claimant is more isolated than in the past and often does things in parallel, and he had difficulty with visual memory and sequencing. His strengths included flexibility, ease with transitions, cooperation, and compliance, while challenges included language processing, speaking up, fine and gross motor, and doing simple activities.

Dr. Bostani also described her home observation which took place during his home CARD program. She indicated he excelled in most areas of the curriculum and had made tremendous strides in his cognitive functioning since his previous assessment. However, she also pointed out there was continued need for progress in the various areas of deficit identified in the assessment, and his impairments hindered his ability to function appropriately and independently in his everyday life. She added that the intensity and consistency of his early behavioral curriculum, claimant has successfully progressed through

a considerable amount of his curriculum and achieved typical functioning in many areas, and he presented with considerable potential to make progress in all of his remaining areas of deficit.

Dr. Bostani identified executive functioning, visual memory, adaptive behavior, theory of mind (perspective taking) and gross and fine motor skills as challenging areas. In addition, other testing disclosed challenges in the areas of language, global visual processing, sensory integration, and motor coordination. She noted that CARD had addressed effectively many of his areas of need. She recommended that the program continue for at least 20 hours a week of one-to-one ABA procedures. She further recommended visual therapy. In school, Dr. Bostani indicated claimant required assistance with social skills, participation, gross and fine motor skills, and significantly delayed written skills. She wanted the children with whom claimant was placed to be appropriate models, and she wanted him placed in a small enough classroom to have the opportunity for greater individualized attention. She suggested a junior kindergarten classroom and a trained shadow aide from his home program. Finally, she recommended parent training.

15. Dr. Jim W. Lam, a family practice physician, in a letter dated January 31, 2005, diagnosed claimant with neuro-developmental dysfunction due to premature birth at thirty-two weeks gestation. He described claimant as having dysarthria/slurred speech and noted speech-language pathologists had diagnosed him with oral-motor apraxia. He indicated that it would be difficult for claimant to outgrow his verbal apraxia and recommended speech therapy three times a week.

On November 28, 2005, Dr. Lam wrote a letter indicating that claimant's occupational therapists continued to have problems with hyptonia and lack of coordination, and he recommended continued OT twice a week for a year.

16. The District conducted a multidisciplinary assessment in May 2006 for a special education update.

a. The district issued a report dated June 6, 2006 and signed on June 8 by Courtney Lewis, School Psychologist. A number of tests were administered over the four-day evaluation.

On the Kaufman Assessment Battery for Children, second edition (KABC-II), claimant's cognitive ability was placed in the average range.

On the Child Development Inventory (CDI), parent report resulted in a rating of general developmental skills at the two year, five month level which is significantly delayed. Parent report also suggested all of claimant's developmental skills fall in the significantly delayed range, including expressive language, numbers skills, self-help skills, social skills, gross and fine motor skills, and letters skills. When claimant's scores were compared to his 2004 scores, they showed only a three and a half month gain in overall development in two years.

On the Test of Auditory-Perceptual Skills-Revised (TAPS-R), claimant's score was in the average range of functioning. All of his subtest scores were in the average range except auditory number memory reversed and auditory sentence memory, which were low average.

On the CDI related to fine motor skills, parent report showed claimant's skills fell at the three-year level which was significantly delayed. He could hold a crayon somewhat like an adult and draw lines and circles, but he could not draw lines that crossed, draw recognizable pictures, cut a simple outline with scissors, draw a square, or color within the lines of a coloring book. Claimant wrote his name and two of his letters were clear but two were difficult to discriminate. As for gross motor skills, parent report placed claimant's ability at the 21-month level which is significantly delayed. Claimant could do a forward somersault, walk up and down stairs, and ride a tricycle. He could not jump over obstacles while running, stand or hop on one foot without support, play catch with other children, or swing on a swing pumping legs independently.

The CDI also asked claimant's parents about his self-help/adaptive skills, and their report placed claimant at the twenty two-month level. Claimant could feed himself with finger foods, drink from a cup, and use a spoon, but he could not use a fork to eat or use a knife to spread foods. He could undress himself, put on a shirt, and put on his shoes, but he could not notice when his clothing was inside out, dress completely without help, button and unbutton buttons, or put his shoes on the correct feet. Claimant is toilet trained and able to stay dry throughout the night. He can wash and dry his hands and brush his teeth unassisted, but is not able to move about the house without supervision, wash himself in a bathtub without assistance, or wash his face independently. His parents reported claimant was not able to take basic responsibility for himself in eating, dressing, and washing when provided with minimal assistance.

On the Scales of Independent Behavior-Revised (SIB-R), claimant's functional independence is reported by his parents to be limited and considered to be at the very low range of a child his age, with an age equivalency of two years and eleven months. His parents reported his abilities in the areas of motor skills, social/communication skills, personal living skills, and community living skills fell in the limited and significantly delayed range of functioning. On the SIB-R completed by claimant's preschool teacher, claimant's scores were in the age-appropriate range with his performance comparable to that of an average individual at his age. Ms. Lewis noted the discrepancy between parent and teacher report, which she interpreted as claimant showing minimal functional independence at home and average-age appropriate independence at school.

On the CDI related to social emotional, parent report placed claimant at the 23 month level which is significantly delayed. His parents reported that claimant was able to play "pretend" games with other children, follow directions during supervised group activities, and follow simple game rules, but he was not able to show sympathy towards other children, he did not usually obey when asked to do something, he will not share toys or possessions, he will not make or build things with other children, did not pay attention well to others, and did not imitate activities with other children. Ms. Lewis indicated she observed claimant during preschool class participate in block building with peers and follow classroom



directions and routines without problems, and throughout the evaluation, claimant was highly compliant.

On the ADOS, the results suggested claimant met the criteria for a classification of autism spectrum disorder due to observed deficits in his communication and reciprocal social interaction. Claimant's efforts to get, maintain, or direct the examiner's attention were limited in scope and range, as was his conversational ability. He also demonstrated limited use of descriptive or informational gestures used to communicate affect. He demonstrated avoidant and inappropriate eye contact during the testing, which required the examiner to call his name several times. His capacity to participate in reciprocal conversation and initiation of social interaction was limited. His play was not creative. During the administration of the test, claimant was not observed to demonstrate any unusual sensory interests or preoccupations.

On the Achenbach Child Behavior Checklist completed by claimant's mother, claimant's scores on the problem scales and emotionally reactive scales were normal, but scores on the somatic complaints scales were in the borderline range, suggesting he reported more physical complaints to his mother than are typically reported. On the Caregiver-Teacher report form, claimant's teacher scored him in the normal range.

On the Woodcock Johnson Test of Achievement-III, claimant demonstrated average pre-academic abilities. Claimant was cooperative throughout the exam but several times, the examiner had to call his name and ask him to look at the test easel.

The evaluation included observation of claimant at his preschool. He complied with teacher directives, group participation, and classroom routines but was less interactive and playful with peers. He participated in group discussion by raising his hand but did not participate with other children on his own initiative. He did participate when another child initiated an activity for a few moments. Claimant's teacher described him as a happy and flexible boy and his greatest weakness was in his fine motor skills for cutting and writing letters. She said claimant intermittently socialized with his peers and enjoyed being a part of his peer group, and he also played in a more solitary manner at times and demonstrated a more limited interest in initiating conversations. She said she had seen him engage in pretend play and he had good memory recall. She felt his strength was in his auditory learning ability rather than visual learning. She believed claimant would benefit for an additional year of preschool before entering kindergarten.

The evaluation summary noted claimant throughout the evaluation demonstrated limited spontaneous interaction and difficulty with pragmatic language. He did engage in imaginative and creative play and social interchanges with his in-home therapists and as reported by his teacher, by his flexibility in pretend play, ability to participate in pretend play initiated by another person, and reciprocal interaction were more limited.

b. A speech and language pathologist issued a report on June 8, 2006. A number of tests were administered and a record review was conducted.

A CDI was administered with claimant's mother as the informant, and his scores reflected those determined in other such testing. His general development placed him at two years, five and a half months.

On the Preschool Language Assessment Instrument (PLAI-2), which assesses the ability of a preschool child to meet the demands of classroom discourse, claimant's scores were in the average range or above. On the Comprehensive Assessment of Spoken Language (CASL), which measures the processes of comprehension, expressions and retrieval, claimant scores were in the average range. Claimant's score on the Assessment of Phonological Processes-Revised, a standardized instrument that provides two assessments using a sentence imitation format, placed him in the mildly delayed range. On the Clinical Evaluation of Language Fundamentals (CELF-PS2), a checklist completed by claimant's mother that assists in evaluating a child's pragmatic behaviors in relation to social expectations for communication in a variety of situation, claimant's score did not meet the criterion score for his age.

Results of oral peripheral and motor informal examination revealed skills within normal limits. Parameters of speech fluency and voice quality were informally judged to be within normal limits for claimant's age and gender.

c. An occupational therapy assessment was performed by the district that included a clinical observation, administration of several tests, and a records review. Fine motor testing placed claimant's grasping skills in the first percentile and his visual motor skills in the 37<sup>th</sup> percentile. He did not present with sensory deficits or sensory motor deficits that would impede him from academic performance. However, concerns in the area of fine motor skills and visual motor skills were apparent as shown by his awkward pencil grasp and inability to form letters. He also struggled with precision when cutting out shapes and bilateral coordination when buttoning and unbuttoning.

d. As adapted physical education assessment determined claimant's gross motor skills were in the average range for his age and he did not qualify for adaptive physical education services.

e. An educationally-based physical therapy evaluation was performed by Orange County Therapy Services due to concerns regarding claimant's coordination and balance. His gross motor skills were assessed using the Peabody Developmental Motors Scales-2 (PDMS-2). On the stationary subtest which measured claimant's ability to control his body and maintain static balance and equilibrium, his score was below average. On the locomotion and object manipulation subtests, he scored in the average range.

Overall, the testing and observations disclosed that claimant presented with deficits in stationary gross motor skills, strength, coordination, and range of motion, but he was able to negotiate various uneven surfaces, including ramps and inclines and stairs, and participate in gross motor activities without concern regarding safety. In addition, he demonstrated appropriate and functional equilibrium and protective reactions to avoid injury when a fall occurred. Therefore, educationally based physical therapy intervention was not

recommended. However, participation in extracurricular activities that would continue to challenge and progress his gross motor skills, coordination, and strength was recommended.

17. In June 2006, Heather Schmidt wrote a Progress Report for CARD. CARD had been providing 20 hours per week of independent therapists and three hours per month of supervision, all of which was privately funded. She indicated claimant engaged in several low-rate maladaptive behaviors including tantrums and non-compliance, which included falling to the ground and crying, when given a directive. She reported that home therapy initially focused on executive functioning and social cognitions but it had been adapted to natural environment training. She described the training as directed at his abilities and behavior in conversation, fine motor skills, gestures, gaining attention, gross motor skills, letters, mock circle, numbers, play, play dates, self-help, sensory, verbal imitation, oral motor, and writing.

Susie Smethurst, a workshop supervisor wrote an IEP Recommendations for CARD. The recommendations included placement in a regular preschool classroom, nine hours per week of a shadow aide trained by CARD, three hours per month of CARD supervision for the regular school year, 20 hours per week of one-on-one intervention, including ten hours of CARD behavioral intervention and ten hours of in home vision therapy supervised by Dr. Ballinger, and annual measurement of his skills.

18. On June 13, 2005, Susanne Smith Roley, an occupational therapist, performed an evaluation of claimant to assess his development and determine the need for occupational therapy services. It was a two-hour assessment. She performed standardized assessments, observed him, reviewed records, and obtained a parent report.

The majority of claimant's test scores fell below one standard deviation from average and indicated areas of concern. He scored in the typical range on the figure ground test of visual perception but scored significantly low on space visualization, manual form perception, design copying, and constructional praxis. His ocular motor skills were poor and he had significant difficulty with ocular motor control and coordinating his eyes, head, and body movements. He had difficulty tracking.

In the area of auditory processing, claimant's mother reported he had difficulty understanding what other people said and claimant appeared not to hear certain sounds. His test score on the praxis on verbal command test was in the average range.

On tactile discrimination, claimant scored significantly low on all tests. These tests are designed to test his ability to localize body parts through touch and distinguish objects through touch. Claimant scored in the low average range on the kinesthesia test. Ms. Smith Roley reported claimant seemed to have somewhat poor proprioceptive awareness for grading his strength, raising and lowering his body, and positioning himself in a chair.

Ms. Smith Roley reported claimant had a history of delayed gross motor skills, and he scored in the below typical range on the bilateral motor coordination test, sequencing praxis, and standing and walking balance tests. Clinical observations revealed poor integration of

basic neuro-motor abilities. Claimant's fine motor skills scores were significantly low and he had significantly poor ocular motor control. Claimant scored in the typical range on postural praxis and below typical on all other praxis tests. These tests suggested his ability to figure out the nature of a game and how to adapt and organize his actions would be impacted.

In summary, Ms. Smith Roley indicated the evaluation showed claimant had significant sensory integration and praxis difficulties, specifically in the areas of somatosensory and vestibular process and motor planning. She reported he had difficulty in fine and gross motors skill development affecting his coordinated movements, and that made it difficult for him to perceive, coordinate, and adjust his actions and make rapid motor accommodations to changes in his environment. She reported he had emotional regulation difficulties and they would very likely affect his performance in the classroom and interfere with his ability to keep up with his peers during play. She further indicated claimant had difficulty efficiently modulating and discriminating information from the tactile system and he is not able to accurately localize and discriminate tactile information. She felt claimant was under-responsive in his vestibular and proprioceptive systems which work together to allow individuals to know where they are in space and organize their movements. She indicated claimant had difficulty with motor planning and refining his movements, particularly when things are complex or moving too rapidly. Finally, she reported claimant had deficits in his ability to perceive, modulate, and discriminate a variety of sensory information and use that information to plan and implement complex and novel interactions.

Ms. Smith Roley's conclusion was that claimant showed relative strengths in his language comprehension, ability to figure out what he has to do through visual cues and his figure ground perception, and he had significant difficulty with visual perception, tactile and kinesthetic perception, vestibular and proprioceptive processing, fine and gross motor control, and motor planning. She believed these issues affected his ability to acquire skills and perform them in a smooth, coordinated manner, and would impact his performance whenever processing speed and accuracy were needed. She recommended occupational therapy of twice weekly one-hour sessions for six months plus supervision to improve sensory discrimination, reduce sensitivity to sensation, and improved fine and gross motor skills and motor planning abilities. She felt attention to his visual and language-based communication skills was necessary and a multidisciplinary approach was in order.

On April 18, 2006, Ms. Smith Roley performed a re-evaluation and wrote a report. She reported that claimant had received speech and language therapy and vision therapy once a week each and one hour a week of occupational therapy through SKY Pediatrics. Ms. Smith Roley assessed claimant in one two-hour session and noted he was shy but did the tasks required of him. He was cooperative and quiet, and at times lost his attention. He separated easily from his mother, showed increased postural control, understood directions, moved rapidly through tasks while sustaining a reasonable degree of competency, he copied designs, sequenced items, and held his pencil with a more mature grip.

On the standardized tests, she observed that three scores declined significantly and two improved, but his raw scores were stable compared to the testing a year earlier, which may have been a related to the fact he was now compared to older children. She believed his

profile continued to demonstrate a child exhibiting visual and somatosensory-based dyspraxia. She concluded the test results showed claimant had made progress in several areas of function, including tactile discrimination and preferred hand skill for writing. He continued to demonstrate significant sensory integration and praxis difficulties, especially in the areas of somatosensory and vestibular processing and praxis. He had difficulty with fine and gross motor skill development affecting coordinated movements. She found it was difficult for claimant to perceive, coordinate, and adjust his actions and make rapid motor accommodation to the speed of change in both the physical and social environment, and he has self-regulation difficulties previously identified. She believed this issue will affect his educational, social, and motor performance and his ability to plan and implement complex and novel interactions.

Ms. Smith Roley concluded claimant had relative strengths in his language comprehension, ability to figure out what he has to do through visual clues and his figure ground perception. But she noted he had significant difficulty with visual perception, tactile and kinesthetic perception, vestibular and proprioceptive processing, and fine and gross motor control and motor planning. She felt these issues affected his ability to acquire skills and perform them in a smooth, coordinated fashion, and will impact his performance whenever processing speed and accuracy are needed. She recommended continued occupational therapy for six months twice a week for an hour, among other things.

19. Claimant was referred to SKY Pediatric Therapy for occupational therapy following Ms. Smith Roley's evaluation. Richard Furbush, an occupational therapist, wrote a progress report in May 2006. He administered the PDMS-2 but could not administer it in a standardized manner as several items were repeated and the administration occurred over two sessions. Claimant's scores placed claimant well below his age and more than two standard deviations below average in grasping and fine motor quotient, and more than one standard deviation below average in visual motor integration. The VMI was also administered over two sessions separated by eight months. His score was in the average range in visual perceptual but very low in motor coordination. His overall score was in the average range.

Mr. Furbush reported claimant had shown improvement in his fine and gross motor skills but he continued to demonstrate need in both areas as well as his ability to safely participate in the demands and occupations in his daily routines. He indicated motor planning issues and visual-perceptual issues impacted his ability to judge distances, react quickly and efficiently to moving objects, and to navigate through unfamiliar environments. He believed claimant's fine motor delays impacted his self-care skills. He reported claimant had shown improvement in emotional regulation. He recommended continued therapy in the areas of fine and gross motor, attention, sensory processing, and motor planning.

20. John Cone, Ph. D., has been a consulting psychologist for the service agency for 15 years, and consulted for several other regional centers. He received his Ph.D. in 1968, and has taught, conducted research especially in behavioral assessments, and written extensively. He conducted an observation of claimant in his preschool class on March 22, 2006 and in his home in March 28, 2006, and reviewed considerable amounts of information. His report of July 5, 2006 broke down the various issues, such as diagnosis and adaptive

functioning, and considered all the information available on each. He summarized the historical information, current information, psychometric evidence, and clinical/qualitative evidence as they related to diagnosis, learning, receptive and expressive language, mobility, self-direction, self-care, and capacity for independent living.

Dr. Cone reported that during his preschool observation, claimant was generally appropriate as he interacted with the teacher and other students. He did not believe claimant manifested characteristics that would permit a diagnosis of autistic disorder. Claimant's teacher told him this was a typical day for claimant. Dr. Cone indicated claimant was attentive to the teacher during chapel and imitated the motor movements of the song being sung; he prepared for snack time, and received cups from the teacher and passed them out to others. Claimant raised his hand in response to a question asked by the teacher and later raised his hand independently to describe a roller coaster ride. He later talked to the teacher about roller coasters and was attentive when other children spoke. He asked his mother for help during puppet play and participated in arts and crafts activities involving cutting and pasting. He showed his work to the teacher and waited for her, and returned to finish the work and took it outside to dry. He then went to the bathroom and washed and dried his hands. Claimant's teacher described claimant to Dr. Cone as "happy, easy going, flexible."

Dr. Cone observed claimant at home working with his tutor, having lunch with his brother and mother, and getting ready to go swimming. Claimant complied with requests and started conversations with his brother and his mother. Dr. Cone felt claimant interacted appropriately with his brother and the five adults present in the home. In addition, he reported that claimant showed age-level feeding skills, drank from a glass appropriately, used a spoon, and refused his mother's offer to cut his meat for him. Claimant used the bathroom at least partially independently by voiding, flushing, and soaping his hands before his mother helped him, and he put on his socks independently.

Dr. Cone concluded that claimant did not appear to have a diagnosis qualifying him for regional center services. He acknowledged several reports referred to claimant as being on the autistic spectrum, but he believed claimant did not meet the DSM-IV criteria for autistic disorder, nor did he meet any of the other statutory eligibility conditions.

Dr. Cone also concluded claimant did not have a disability sufficient to meet the statutory and regulatory requirements for regional center services in that claimant did not have substantial deficits in adaptive behavior related to a qualifying diagnosis. In terms of learning, he pointed out several IQ tests placed him in the normal or low normal range.

In the area of receptive and expressive language, Dr. Cone believed claimant's skills were at age level during the observations, and noted claimant did not show echolalia, pronominal misuse, or problems with register or prosody. He added claimant's imitative repertoire was well developed, he learned from others, he was relatively quiet in school, he raised his hand appropriately and told his teacher about a roller coaster and a caterpillar, and spoke constantly at home. He pointed to psychometric evidence which in his view showed claimant scored in the average to low average range.

In terms of mobility, Dr. Cone indicated claimant walked and ran a distance of 20 feet or more without assistance, and while he seemed to run awkwardly and was reportedly delayed in gross motor skills, he was well coordinated on a trampoline. He noted claimant's test scores placed him in the average to low average range.

In the area of self-direction, Dr. Cone referred to his observations of claimant at home and at school, and test results to conclude claimant was not substantially handicapped. Similarly, in the area of self-help, he based his conclusion on his observations and test scores, although they seem to be lower than in other areas.

Dr. Cone concluded his report with a list of recommendations including involving claimant in highly structured, behaviorally-oriented experiences at home and at school, inviting claimant's parents to training classes at the regional center in positive behavior management, and so forth.

#### Other Documentary Evidence

21. CARD therapists created a series of goals and objectives to be reached by June 2007, with a description of his current level of functioning. The goals and objectives provided claimant would be able to:

a. Join in cooperative, symbolic and pretend play with familiar peers or groups of peers in school settings. He currently engaged in parallel play in the school setting in approximately 70 percent of opportunities;

b. draw ten simple pictures when asked to draw something like a car with 80 percent accuracy. He currently was able to draw a variety of stick people, and required both the use of model and dot prompts to create various pictures in approximately 80 percent of opportunities;

c. print his first and last name without transcribing/reversing letters in four out of five opportunities. He currently was able to write the letters L and U with the use of dot prompts in about 80 percent of opportunities;

d. print all lower case letters in four out of five opportunities, He currently was unable to write any lower case letters without prompting;

e. use present, past, and future tense verbs correctly in his spontaneous language in four out of five opportunities. He has currently mastered 17 past irregular actions;

f. engage in ball play for at least five minutes with peers on the playground to include throwing, catching, and kicking a ball four out of five opportunities. He currently required adult prompting in about 90 percent of opportunities to bounce, kick, throw, and catch a ball;

g. expressively identify 26 phonetic sounds utilizing “zoo phonics” in the classroom four out of five times. He currently could identify 19 letters of the alphabet but did not identify any phonetic sounds;

h. recognize subtle cues (facial expressions, body language, eye contact, etc.) given by an adult or peer and modify his behavior in actual situations in four out of five opportunities. He currently was able to identify 17 gestures in a structured setting.

i. upon initial “mand” will wait for an appropriate response from a peer or adult before repetitive “manding” in four out of five opportunities. Currently, if he is required to wait for an adult’s attention, he will repetitively “mand” for desired object/activity in about 90 percent of opportunities;

j. ask appropriately for clarification or help when vague/misunderstood information or directions are given across various settings in four out of five opportunities. Currently, if claimant did not understand directions, he will guess continuously and required verbal prompting in about 90 percent of opportunities; and

k. receptively and expressively identify numbers 1 through 31 using multiple exemplars across settings measured in four out of five opportunities. He currently can identify numbers 1 through 12 with about 80 percent accuracy.

22. Claimant furnished a large notebook containing hundreds of documents relating to his therapy sessions with CARD for the period February 2005 to May 2006. It is impossible to summarize all the information contained in the notebook.

23. Claimant’s mother prepared a list of examples showing claimant’s functioning in each of the five areas of major life activities. In the area of self-direction and mobility, she wrote claimant loses his balance climbing down the three steps of the trampoline and falls, he falls out of his chair during mealtime or when he does focused work, he did not stop running when ordered to stop, he and claimant’s brother dropped to the floor and rolled on the ground in a market and would not listen to her, he forgets where he is going or watch for cars, he hangs onto her for pressure, he darts, and he cannot keep up with other children when playing soccer or kick the ball when it comes to him.

In the area of self-care, according to claimant’s mother, he can use a spoon but has difficulty with a fork or knife, he misses his mouth when using a utensil and creates a mess, he can put on his clothes but in the wrong direction, and he cannot button, snap, or zip his pants, and he has trouble getting his shoes on the correct feet. Claimant has trouble watering and washing his hair or putting his head under water, and hates the feel of water on his face. Claimant cannot hold a crayon for any length of time and gets very tired when trying to color or write his name, he cannot write his name and his mother is experimenting with sensory or auditory approaches rather than a visual approach to writing his name, but it took him a year to learn to write the letter L and now can write L U and E pretty consistently. When claimant becomes tired, he turns his head and covers an eye with his hand, and can perform fine motor manipulation better when blindfolded.



In the area of learning, claimant's mother wrote it has taken claimant a year and a half to learn numbers 1 through 9 and the alphabet, and could not learn from visual cues alone but needed five different sensory books, and needs constant repetition or he will lose his skills. Claimant cannot write his name or color, he cannot maintain a tripod grip; he becomes fatigued after five minutes and wants to disengage. According to his mother, 80 percent of his peers can write their names and color for extended periods of time. She described an incident when claimant looked at a large visual array, closed his eyes, his hands went to his eyes, and he started moving his body from side to side, without responding to a question from his teacher. Claimant has trouble with visually sequencing information and cannot imitate songs or hand movements to songs, or recalling the words to songs.

In the area of language, claimant's mother wrote claimant cannot move his tongue correctly, he cannot lateralize his tongue or move it to the top of his mouth, he has a weak jaw, and it is therefore hard for him to articulate properly. Claimant has trouble motor planning sequencing of words, particularly words with several syllables. She wrote claimant cannot sequence three-step directions, making it hard for him to keep up at home and at school. Instead of giving claimant three directions at a time, like eating breakfast, brushing his teeth, and putting on his shoes, claimant's mother has to verbally prompt him for each activity individually. She indicated claimant mispronounced pronouns, omitted words, and used past tense incorrectly, and he has poor articulation, making it difficult to understand him. In her opinion, pragmatic (social) language was claimant's biggest deficit in that he does not join in groups to play, he mostly parallel plays, he does not engage in cooperative play, and he has poor eye contact. She gave an example of claimant refusing to answer questions posed by her teacher and other children.

24. Claimant's mother went to Grace Preschool on March 22, 2006, the same day Dr. Cone did, and wrote an observation report. She described snack time when claimant did not answer questions or describe his vacation when asked. She observed him parallel play with puppets and not speak to other children. When his teacher asked him to put a caterpillar together, claimant was unable to do it. Nor could he write his name other than the letter L on his art project. Claimant did not follow hand movements to a bible story and did not sing. She wrote that claimant was unable to pick out an object that the teacher had removed from a group of food items.

#### Hearing Testimony: Regional center witnesses

25. Marilyn Thompson, claimant's service coordinator, testified she participated in the home observation on August 1, 2005. She spent about three hours observing claimant and his brother. She testified claimant was active during the visit, ran up and down stairs awkwardly, made intermittent eye contact, spoke in sentences, understood commands, stayed on task despite distractions, and talked to her about superheroes. She testified the therapist who was present told her his transitions were mild with non-preferred activities and his mother said he used a toilet.

Ms. Thompson observed claimant in school on March 22, 2006 with Dr. Cone. She testified claimant followed directions, sang a song, was quiet, had no problems transitioning from the chapel to the classroom, talked about a roller coaster after raising his hand and being called upon by the teacher, cleaned up without problem, completed a craft project, and interacted with other children, but only minimally. He played alongside other children in parallel play, but it was imaginative. She did not observe any challenging or repetitive behavior nor did he ever fall.

Ms. Thompson also observed claimant at home on March 28, 2006 with Dr. Cone. She testified claimant was in a playful mood. At one point, he ran across a room, smiled, and looked at his aide. The aide gave him prompts. Even when claimant was non-compliant, Ms. Thompson noticed claimant smiled and appeared to be playing. She testified claimant talked about going to Sea World, played on a trampoline, asked his mother for cough medicine when he started coughing during lunch, and used a spoon to eat lunch with minimal spillage. He also ate with his fingers. He used the bathroom independently and put on some of his clothing independently, but needed his mother's assistance. She did not observe any repetitive or tantrum behaviors. His therapist told her claimant was more resistant than usual that day.

Ms. Thompson testified she did not observe any regression of claimant's abilities in the nearly eight months between observations, and in her opinion, claimant did not have substantial disabilities in three or more of the requisite areas.

26. Arlene Downing, M.D., is the director of the health resources group for the service agency, a team consisting of nurses, doctors, psychologists, and others who work together on issues involving eligibility and training. She has worked for the service agency for twenty years and has considerable experience determining eligibility. She reviewed claimant's request for services and the information available, and concluded on September 30, 2005 that claimant was not eligible for regional center because he did not have a substantial disability.

In reviewing the records, Dr. Downing was looking for a description of claimant's development—what he could do—related to age expectations, medical workups, diagnoses, and recommendations. She noted from Dr. Donnelly's March 3, 2003 report that claimant was the product of a high-risk pregnancy, was premature, and experienced problems early in his development. She found that claimant was delayed but communicative with a social intent, and Dr. Donnelly did not believe he was autistic. Based on his report, Dr. Downing did not believe claimant was autistic. In Dr. Donnelly's June 24, 2003 report, when claimant was 26 months, Dr. Downing found he had made gains and while there were global delays, he was social and interactive, and did not meet DSM-IV criteria for autism. She noted claimant imitated and pointed to body parts, and children with autism did not do these things. Dr. Downing noted that in Dr. Donnelly's November 3, 2003 report, claimant had behavior and language issues and developmental delays, but noted the regional center and CARD did not believe he was on the autistic spectrum. She noted that claimant's mother reported gains in vocabulary, indicating progress.

In Dr. Donnelly's June 8, 2005 report, he pointed to progress but concerns in school, Dr. Bostani's report and diagnosis, and a speech pathologist who observed poor eye contact. Dr. Downing indicated Dr. Donnelly found claimant seemed to meet the DSM-IV criteria for autistic disorder, but on the milder end of the spectrum. She interpreted his report as showing he was going along with the diagnosis by Dr. Bostani, but his diagnosis was "soft" and not a conclusive diagnosis in that it could also be a diagnosis of Asperger's or PDD-NOS.

Dr. Downing reviewed Dr. Ballinger's May 9, 2005 report and concluded that Dr. Ballinger's description of claimant's symptoms and history showed he needed to but was unable to focus, and she explained this could be found in any child with a birth history like claimant's. She did not believe this was related to autism and would not be the basis for indicating a failure to maintain eye contact, and thus was not a regional center eligibility condition. Similarly, she explained that Dr. Lam's letter of January 24, 2005 with its recommendation for speech therapy, was for insurance purposes, but did not represent a regional center eligibility condition.

In Dr. Downing's review of the relevant medical history, she testified she found no evidence of any substantial handicap in the areas of mobility, self-direction, and self-help. She did not consider psychological information such as psychometric testing. She pointed out claimant's IQ scores indicated he did not have a disability in the area of learning, and he therefore had abilities to overcome his developmental disabilities. She believed claimant's deficits in motor planning probably related to apraxia. She felt social interaction and communication deficits were the hallmark of autism, and claimant did not exhibit them.

27. Mary Parpal, Ph.D., is a psychologist with the service agency whose duties include reviewing eligibility. She reviews about 25 to 50 applications for services a week. Previously, she performed assessments. She reviewed claimant's application for eligibility on September 27, 2005, beginning with the early start records, and concluded that regardless of his diagnosis, claimant did not demonstrate substantial disabilities in three or more of the requisite areas. She concluded his learning was average, his mobility was within normal limits, and his expressive and receptive language was within normal limits. She believed his self-care was mildly delayed but he did all right for a child his age.

Dr. Parpal pointed to a number of reports to substantiate her conclusion. In the CARD report of January 29, 2004 which recommended six hours of parent training and the Rainbow Kids discharge summary of March 26, 2004 which disclosed some delays, she found no indication of any substantial disabilities. The district's multidisciplinary assessment of March and April 2004 made claimant eligible as speech and language impaired, not because he was autistic. She noted a decision by a school district to make a student eligible for special education services has a lower standard than a regional center determination of eligibility. She added that the district's testing showed mild motor delays, the Bayleys results were within normal limits, the ADOS did not find him to be autistic, and the language scales were within normal limits. Another aspect of the district's assessment involved occupational therapy. She interpreted the findings to show that claimant was capable of getting from one place to another, which she believed was the definition of

mobility, without a walker or wheelchair, and despite delays in fine motor skills, was in the low average range.

Dr. Parpal noted an IEP dated April 23, 2004 indicated areas of strength in receptive and expressive language and social-pragmatic communication skills, but a concern with articulation. She interpreted the May 5, 2004 report of Ms. Almeida as evidence that claimant had age-appropriate expressive language skills. Dr. Parpal interpreted Ms. Hein's report of June 25, 2004 as showing his speech and language were within normal limits, and no behavior issues were raised.

In Dr. Bostani's report, Dr. Parpal pointed out that claimant took the WPPSI-R, which she described as a difficult test to administer to children, and few are given it, because it requires self-control, the ability to follow directions, and the ability to sit long enough to complete it. The test showed claimant could use language to express himself and make himself understood, and his results were average in verbal and borderline in performance. She added that Dr. Bostani should not have reported a full scale IQ of 80 because of the big difference between the verbal (90) and performance (73) tests. In her view, this test showed claimant had no substantial disability in the area of learning and language.

Dr. Parpal disagreed with Dr. Bostani's interpretation of the BRIEF-P results. Dr. Bostani wrote that the excessively high scores were typical of a child with autism; Dr. Parpal testified the scores were not specific to children with autism but could also be attributed to other problems such as ADD. Dr. Parpal further pointed out the Vineland was the product of a parent report and was not a direct assessment, yet even on that test, claimant's score in the area of communication was adequate, and only his motor skills score was low, while the others were in the moderately low or borderline range.

In connection with the CARS administered by Dr. Bostani, Dr. Parpal did not know where the information came from. Dr. Bostani did a school observation but did not describe what she observed. Dr. Parpal wondered if there might be some subtle areas of deficits, but Dr. Bostani did not indicate what the deficits were. Nor, according to Dr. Parpal, did Dr. Bostani indicate what DSM-IV criteria claimant met that would support a diagnosis of mild autism. Dr. Parpal added that the diagnosis of autism in the mild range impacted the decision on whether the disability is significant.

Finally, regarding Dr. Bostani's report, Dr. Parpal testified that the Leiter, which tested intelligence, showed average results except for forward memory.

Dr. Parpal also reviewed Dr. Bostani's second report of May 2006. She noted claimant significantly improved his IQ scores, and the difference between the verbal and performance scores was only eight points, thus rendering the full-scale score of 103 valid. She pointed out claimant's subtest scores were average to superior. She observed that claimant's comprehension was high and he could verbalize questions to a therapist, he understood standardized test questions, and responded verbally. Dr. Parpal also pointed out claimant's score on the BRIEF-P relating to pragmatic language was in the average range, and this tested social language. She noted the scores on the Leiter were similar to previous

testing, although abbreviated, and on the Vineland, claimant's communication was within normal limits, but his socialization and motor skills scores were low.

Dr. Parpal testified there was a discrepancy between Dr. Bostani's report that claimant did not use utensils when eating, and the CARD reports that showed claimant did use utensils. Dr. Parpal noted that in Dr. Bostani's description of the school observation, claimant demonstrated appropriate eye contact, he was focused, he answered questions, he responded socially and appropriately when a conflict between peers arose, and reported the incident to the teacher. Dr. Parpal noted he was interacting but also was alone at times, and he had trouble writing letters, but memory tests showed he was learning. Regarding the home observation, Dr. Parpal testified a CARD supervisor was there and they had stopped discrete trial training because he did not need that training any longer, and was doing well in the program. She added there were no reports of self-stimulatory behavior and that Dr. Bostani indicated claimant had considerable potential, which indicated the disability may not last indefinitely and that he would not need an agency to organize his life in the future.

Dr. Parpal considered Dr. Dore's assessment, and noted he observed minimal problems at home. She pointed out claimant was resistant to brushing his teeth and having water on his head, but he ate breakfast without incident, transitioned well, and exhibited no unusual or challenging behaviors. In addition, claimant's teacher did not identify anything to show that claimant was different from other children. She did not believe that anything described by Dr. Dore was different from a typical three-year-old.

Dr. Parpal reviewed Dr. Donnelly's report of June 8, 2005, which reflected the fourth time he had seen claimant. Dr. Parpal disagreed with Dr. Donnelly's observations that claimant had difficulty in school as shown by Dr. Dore. Dr. Parpal testified that Dr. Dore did not report significant problems at school. Regarding Dr. Donnelly's diagnosis of autistic spectrum, she pointed out it was at the mild end, the diagnosis was vague, and it did not seem to be a strong one. She noted that Dr. Donnelly reported claimant exhibited fewer tantrums and showed a communicative intent.

Dr. Parpal reviewed Ms. Hein's March 10, 2006 report and found no substantial disability in language but rather that claimant scored within normal limits. She disagreed with Ms. Hein's prediction of future difficulties, testifying that there was no evidence to support it. She pointed out that all children have more difficulty as they get older, and that it was her responsibility to decide issues of eligibility on current levels of performance, not future predicted levels.

Dr. Parpal pointed to the June 2006 CARD progress reports as showing claimant's behaviors at home had improved. She testified the rates were low, and most children claimant's age were non-compliant, yet he was doing better in following directions and responding to age-appropriate questions. She agreed claimant had fine motor skills delays, but pointed out this was not an eligibility criterion. She noted the report showed claimant had mastered running, rolling a ball, going up and down stairs and alternating his feet, he used a fork and spoon correctly, and he could brush his teeth and use a bathroom. She expected his progress would continue.

Dr. Parpal testified she reviewed a 2006 IEP which showed claimant's academics were in the average range, and on the Woodcock, which few regional center consumers can do, claimant scored in the average range. In the May 2006 district assessment, Dr. Parpal found numerous discrepancies between parent reports of claimant's behavior, and standardized assessments or reports of other persons. She felt claimant was learning, and pointed to a teacher report that indicated claimant had great skills and showed cognitive development, he could cope, he showed mature emotional growth, he engaged in solitary and cooperative play, and could be talkative. She testified claimant's cognitive and academic scores were average as was his overall functioning. Dr. Parpal testified the district used the ADOS, which she described as the gold standard, to determine that claimant met the cutoff for autistic spectrum disorder, but not for autism. Based on this report, Dr. Parpal concluded claimant had average intellectual functioning and his auditory processing was average, and academically he was within normal limits. She did not see any evidence of substantial disabilities or of any disability that could be expected to last indefinitely. She believed claimant was more capable of performing well at school than he was at home.

Dr. Parpal also reviewed the reports of Dr. Ito and Dr. Cone and again found no evidence of substantial disability. She noted the reports showed claimant was doing well and making good progress, and there was no reason to expect this would not continue. She complimented claimant's family for their efforts. She testified claimant was toilet trained and he could dress and feed himself, thus showing his self-direction was within normal limits, and his socialization was all right. Lastly, parent and teacher report showed no clinical symptoms of anxiety, emotional withdrawal, attention seeking or aggressive behavior, affective disorders, ADD, or other pervasive problem.

28. Dr. Cone testified he became involved in claimant's case after his parents re-applied for regional center services, the service agency denied the application, and his parents appealed the decision. He did not participate in the original decision which found claimant was not eligible for regional center services. He was asked to review claimant's records to determine the level of his adaptive functioning, and not to make an independent diagnosis. He reviewed records and performed multiple direct observations. His testimony reiterated the opinions he set forth in his report.

Dr. Cone testified that while he did not make a diagnosis, he formed an impression regarding claimant's diagnosis and did not believe autistic disorder using the DSM-IV criteria were met. He noted claimant acted appropriately in school and he saw nothing in the records to show that claimant met the DSM-IV criteria for autistic disorder. He added that Dr. Bostani did not undertake an analysis of DSM-IV criteria to support her conclusion that claimant was autistic, and appeared to rely on only one test score.

The structure of Dr. Cone's testimony was similar to his report. He reviewed all the evidence available in each of the five major life areas as required by the Lanterman Act. Regarding learning, Dr. Cone noted that claimant's test scores typically were lower when he was younger, but they improved over time, and he was currently age typical. He pointed out that claimant was born prematurely, and there was some catching up, and in addition, he had

received very good services. He believed the evidence showed claimant has the ability to learn and has learned, and is not globally delayed.

During his observation of claimant at school, Dr. Cone testified that claimant's aide was involved in his fine motor activities, but not much else. He testified children with autism do not typically share their experiences, but claimant did in class, and when he went up to the teacher, he was not prompted to do so by his aide.

Regarding language, Dr. Cone believed claimant was at age level. He found no evidence of echolalia or other symptoms typically associated with autism, and claimant had good language available to him. He indicated claimant's mother was very good at encouraging language. As far as the objective evidence is concerned, again claimant's scores started out low but increased over time, to a point where he believed claimant was at the low normal level of functioning.

In the area of mobility, Dr. Cone agreed with Dr. Parpal that not much was required of a consumer in order to determine if he or she were mobile. In essence, it is the service agency's position that if a person can move from one point to another without assistance, then he or she is not eligible for regional center services. Dr. Cone observed claimant walk without assistance, and run awkwardly. Claimant also could play on a trampoline. Dr. Cone did not believe that claimant's daily functioning was handicapped.

Dr. Cone reviewed claimant's records in the areas of self-direction and self-care with an eye toward determining if there was appropriate development. He pointed out there was a significant difference on the ABAS in both areas when claimant's teacher reported information compared to claimant's mother. Claimant's mother's scores were always considerably lower. Dr. Cone reviewed data accumulated by CARD and noted most of the goals were academic and adaptive behavior. The data showed claimant took all steps appropriate to brush his teeth, eat, and dress. He used utensils and did not require prompts for eating. He appeared to be compliant. Dr. Cone never observed anything which made claimant stand out, and believed all the information showed claimant did not have a substantial disability. Rather, he believed the data showed claimant was making very good progress over more than a year and the descriptions of his behavior showed him to be at age level. Furthermore, he did not believe claimant's condition would last indefinitely because he had improved, the trajectory was up, and he was in low normal range in many areas. He assumed claimant would continue to improve and saw no need for lifetime services.

In Dr. Cone's report, he created two graphs of each of claimant's scores in the five major life areas. For the period from October 2002 to mid-2006, he found that the mean score in each of the areas was in the low 80s, except self-care which was below 80. One standard deviation in a standard score is a score of 85, and two standard deviations is 70. In Dr. Cone's view, a standard score of two or more standard deviations below the mean indicated a substantial disability. Dr. Cone's graph also showed some of claimant's highest scores in every area but self-care was close to average, or age typical. For the period from March to June 2006, Dr. Cone found that claimant's test scores on the ABAS-II and

Vineland averaged in the low 80s. This graph showed how differently claimant's mother and teacher rated claimant's abilities.

Dr. Cone reviewed Dr. Bostani's 2006 report and testified his impressions were not changed by the new information contained in it. He noted the test result on the WPPSI-III was similar to Dr. Ito's findings, both of which were average. He compared claimant's results on the Leiter to earlier results and found there was a problem only in forward memory. Based on this test and the TOPL, he concluded claimant's executive functioning was average. He again noted that the scores on the Vineland and BRIEF-P were based on parent report.

Dr. Cone reviewed Ms. Smith-Roley's report and noted that there was little progress in sensory integration. In his opinion, sensory integration does not have empirical support and the therapies based on sensory integration have no support.

#### Hearing testimony: Claimant's witnesses

29. Susanne Smith Roley testified she is a licensed occupational therapist and specializes in children with learning behavior issues. She performed two evaluations of claimant. She did not provide any therapy. She reiterated the findings she documented in her reports. After evaluating him twice, she found that there was vulnerability in his family. She believed his gross motor scores showed his deficits to be severe. In her opinion, a standard deviation of more than one was significant.

In Ms. Smith Roley's opinion, claimant had made progress in several areas of functioning and was able to tolerate separating from his mother and paying attention during testing. He could rapidly move through tasks while sustaining a reasonable degree of competency. He showed gains in tactile discrimination and preferred hand skill for writing. However, he had significant sensory integration and praxis difficulties, fine and gross motor development difficulties, and it was difficult for him to perceive, coordinate, and adjust his actions quickly. She believed his motor difficulties due to poor coordination and balance constituted a safety issue. She felt he also had self-regulation difficulties as well as visual, speech, and language difficulties. She believed these difficulties would affect his educational, social, and motor performance, and his ability to plan and implement complex and novel interactions.

Ms. Smith Roley testified claimant was more difficult to test in 2005 than 2006, but he still needed reminding and prompting to stay focused. She observed that he was significantly different from other children. She thought he had ocular deficits in that he had trouble looking out of both eyes. She called this a "red flag." She noted claimant fell off his chair during testing and believed it was because claimant did not pay attention to his body in that he lost his sense of where his body was. She also observed involuntary tremors, low tone, and that claimant tired quickly.



30. Joanne Hein is a speech and language pathologist in private practice for the last twenty years. She obtained her masters degree in 1976 and has worked with autistic children since then.

Ms. Hein's testimony was inconsistent with her reports and is given little weight. Her reports provide a balanced evaluation of claimant's strengths and weaknesses. Her testimony, however, obscured his strengths and sought to portray him as substantially disabled. She emphasized low scores and criterion scores, which had only cutoffs, and were not standardized, and disregarded higher scores, particularly those she had emphasized in her reports.

31. Beth Ballinger is an optometrist who specializes in visual functioning for children with developmental disabilities. Her testimony mirrored her report. She has seen claimant about 25 times. In her opinion, claimant has global motor difficulties which negatively impacted his ability to perform many tasks such as buttoning, zipping a zipper, tying shoes, riding a tricycle, writing with a pencil, using scissors, and so forth. She found that his visual problems caused him to squint, close one eye, and then avoid a task because he became overwhelmed. She termed it a convergence insufficiency. In addition, claimant had poor peripheral vision and had trouble following objects. She testified claimant's inability to determine depth caused him to crash into objects because they were closer than he thought they were. She testified claimant did not have control over the muscles of his eyes and could track objects only by turning his head.

Dr. Ballinger testified claimant needed information repeated to him many times under many circumstances, and he was unable to generalize information. She noticed claimant used his hands to help him see where objects were and when he was asked to reach for an object; he did so slowly, indicating he was not sure where it was. She also noticed that during therapy, claimant slurred his words and was difficult to understand, and he had difficulty with word retrieval.

In Dr. Ballinger's opinion, the way claimant responds to a test is not the way he handles situations in his life. He usually spoke in one to three word sentences, or pointed, and did not use complete sentences. Claimant usually took a long time to make a judgment, and Dr. Ballinger testified she could "see his wheels turning." She believed this caused him to become overwhelmed. It also took him a long time to complete tasks. He became distracted easily and went off task. She determined claimant took a long time to integrate information from two sources and he had difficulty multi-tasking.

Dr. Ballinger determined that claimant scored low in spatial relationships, which might have the effect of him running into a street without seeing a car. She believed he was not aware of what was around him and this caused him to trip and hurt himself, or run slower than other children. It could also affect his ability to learn letters and retain what he had learned. She was concerned about his ability to process letters and numbers as he got older and had more information to process. In terms of socialization, she found that claimant might not look and see gestures and get cues from them.

Dr. Ballinger emphasized that speed and precision in completing test questions were two different components and often claimant might do what was expected of him, but it took him a very long time. She added that she did not see him as being consistent, in that on some days he did well and on others he did not.

32. Mitchel Perlman, Ph.D., is a clinical psychologist and maintains a private practice specializing in assessments in the areas of special education including autism, probation, and child custody, with some therapy. He has been licensed for twenty years and considers himself a neuro-psychologist. He received extensive training and cross-training in psycho-educational assessments. He received some training in ABA therapy for children with autism but does not provide therapy to such patients. He has never worked for a regional center or performed an evaluation for a regional center, but he has attended IEP meetings. He reviewed claimant's records and testified in order to clarify data relating to test scores. He did not make a diagnosis of claimant and did not assess him.

In order to illustrate his evaluation of the reports generated by the numerous professionals who had assessed claimant over the years, Dr. Perlman created a chart, which listed the result of each assessment as it related to the five major life areas: self-care, receptive and expressive language, learning, mobility, and self-direction. He concluded claimant had substantial disabilities in each of the areas based upon his review of the standardized tests and the comments made by evaluators in their reports. In several areas, some scores from one test would show a substantial disability while other scores would not show a substantial disability, and when that occurred, Dr. Perlman used his judgment to reach his conclusion. He testified that while some test results were high, claimant's pragmatic application of the tested skill was low.

In the area of language, Dr. Perlman pointed to the District's 2006 evaluation, Ms. Hein's report, and Dr. Ito's report. Dr. Bostani's tests showed no substantial disability in this area, but Dr. Perlman felt those findings were outweighed by Ms. Hein's CELF criterion scores and recommendations, the District's CDI, SIB-R, ALPHA-R, and CELF-PS2 results, and Dr. Ito's ABAS-II results. In addition, he quoted from the District's report, which had observed "Throughout the evaluation, [claimant] demonstrated limited spontaneous interaction and difficulty with pragmatic language." He also quoted from Ms. Hein's June 2004 report who had noted "While many of his expressive language skills were within the average range for his age, there was a definite weakness noted in this area...his ability to include all needed parts of language to express his ideas clearly and at an age-appropriate level remains impaired." Dr. Perlman testified he found a pattern in claimant's test scores—even if the quantification were high, when he looked at the pragmatic level and the way it played out, claimant's ability was low.

In the area of mobility, Dr. Perlman testified nearly all test scores pointed to a finding of substantial disability. He pointed to a VMI score of 80 from Dr. Ito's report, and the CDI, SIB-R, and PDMS (for fine motor) results from tests administered by the District in 2006 to support his conclusion. He testified that in this area, claimant's score might have stayed the same over time, but that would be translated into a lower overall score because more would be expected of him as he got older.

In the area of learning, Dr. Perlman found that the scores reflected in the District's 2006 evaluation were average, but they were outweighed by Dr. Ito's report of the ABAS-II test and her observation that there might be some factors which were interfering with his ability to reach his potential in terms of functioning at home. He also relied upon Ms. Smith Roley's findings, Dr. Ballinger's findings, and the results of the BRIEF administered by Dr. Bostani. He felt the BRIEF showed claimant was more impaired than he had been previously and attributed it to a problem with working memory.

In the area of self-care, Dr. Perlman testified that all the scores had consistently showed he was substantially disabled. He pointed to such scores as the VABS, Daily Living administered by Dr. Bostani, the CDI and SIB-R administered by the District in 2006, Dr. Dore's comments, and the ABAS-II administered by Dr. Ito. He noted that the scores became lower as claimant got older and he could not determine if claimant were progressing at the same rate as his peers.

Dr. Perlman testified that in the area of self-direction, claimant's scores were very low, and consistently in the first percentile.

Dr. Perlman was aware claimant was receiving services from a number of sources. He testified that when services stopped, children with autism often regressed. In his experience, services have to be intensive in order to get some movement, and they have to be pertinent.

33. Claimant's mother testified at length and described the level of claimant's functioning. Claimant and his identical twin brother were both born prematurely. She has an older son who has been diagnosed with autism and there is an uncle in the family who also suffers from autism. She testified that after she brought claimant home from the hospital, he screamed for 18 hours a day for three months, until he finally calmed down at age six months. When he had not started walking by 15 months, was not speaking, and was not making good eye contact, claimant's mother became concerned and contacted the service agency. Claimant then began receiving Early Start services including speech and physical therapy from Rainbow Kids. During this time, she felt claimant was very delayed in the area of language.

In January 2004, before claimant turned three, his mother received some training from the service agency, and in March 2004, she asked the service agency for services. She testified the service agency determined claimant was not suffering from autism, and denied eligibility. However, she contacted the District which found delays but not autism, and it provided speech and occupational therapy. According to claimant's mother, the speech therapist told her that she believed claimant was autistic. Claimant's mother decided to find out if that were true. She first had claimant evaluated by Ms. Hein, who advised her that claimant's receptive language was not where it should be and he had horrible eye contact. In addition, claimant, according to his mother, did not hear and see well, and this affected his functioning. He also had a difficult time articulating his speech, and he often omitted words

or syllables. She then took claimant to Dr. Bostani who diagnosed autism, and she was horrified at his low IQ and achievement scores.

Claimant's mother decided to pull claimant out of school and begin therapy with CARD. She testified that claimant had potential but his functioning did not reach his potential. As an example, she testified that during therapy with CARD, claimant could brush his teeth, but he could not do that at home. The same was true for potty training. She believed claimant could not generalize and pointed to his Vineland test score as evidence.

In addition to CARD and speech and occupational therapy, claimant's mother had claimant evaluated by Ms. Smith Roley to try to understand claimant's "gaps." The findings were significant, showing substantial handicaps in such things as holding a pencil or maintaining his balance. Claimant's mother testified claimant often falls out of a chair, and puts his hand over his eye when he has trouble tracking an object. She attributed claimant's inability to write his name to his visual problems. She added that his proprioceptive ability was out of kilter, and that was why he was given a trampoline, which has proved helpful.

Claimant's mother described an observation she made at school. The teacher told the students to look at an array of objects, she then removed one, and asked them to tell her which one had been removed. Claimant had not idea what was expected of him and was unable to follow the direction or determine what had been removed.

Claimant's mother organized her testimony around the five major life areas to show that his functioning was substantially disabled. She prepared a chart and list of examples. Claimant's mother gave an example of an incident when claimant lost his physical orientation. He had just gotten out of a car that was stopped in a parking lot, but he seemed to lose his body awareness and fell backwards. She testified Ms. Smith Roley's findings confirmed his motor issues. She added that claimant had oral motor issues in that he cannot move his mouth correctly, and has received programming to address that.

Claimant's mother fears that despite all the services she and her husband have provided for claimant, including CARD, vision, and occupational therapy, there are still many gaps, and if he stops receiving services, he will be a mess. She believed claimant could get better, and noted some of his scores were improving.

According to claimant's mother, there are many examples of claimant's behavior to show he is autistic. She indicated his language was delayed, his social language was not normal, he did not play cooperatively but in a parallel way, he never raised his hand in class, he does not appreciate subtle cues, he does not answer questions, he has horrible eye contact and will look to the side because eye contact is stressful, and he cannot generalize. In addition, he has oral motor issues, articulation issues, and motor apraxia. She testified everything with claimant was heightened, including many sensory activities like washing his hair (he screams) and brushing his teeth. She indicated claimant was a very picky eater, makes a mess when he eats, and has many noncompliant behaviors. His tantrums started when he was two years old, and included screaming and resistance to getting dressed, thereby causing his mother to routinely bring him to school late. She estimated he has three

tantrums a day, each lasting ten to thirty minutes. She handles this by placing him in time out, but she reported he did better during therapy than with her. In her view, claimant cannot “self calm” or know how to get attention appropriately. Another problem claimant’s mother reported was “darting.” In one example, claimant and his brother were in a grocery store when they both took off running out the store and did not stop despite many calls. Claimant’s mother had to chase them, and after she caught them and brought them back into the store, and while she was in line to pay for her groceries, the boys dropped to the floor, rolled around, and hugged each other. On another occasion, while in church, claimant and his brother ran through a parking lot, not stopping when called, and were almost hit by a car.

Claimant’s mother testified claimant was not coordinated enough to kick a soccer ball, although he plays on a soccer team. She did not believe he could handle the visual array or imitate motor movements necessary to kick a ball. In addition, she noted claimant could not perform two physical tasks at the same time such as sing a song and move his hands. She felt his motor planning was poor. When claimant is climbing stairs, he does all right as long as he holds onto the rail, but he does lose his balance. She noted losing his balance in other situations occurred most often when claimant was concentrating intensely on something else, such as when he was eating or writing, and as a result, he would fall out of a chair and injure himself. She testified claimant fell about twice a day, and screamed and overreacted.

In the area of language, claimant’s mother testified that claimant often pronounces words incorrectly, and when he does so, she pulls out his tongue to help him feel where his tongue should be in order to make the correct sound. She testified he needed speech therapy, but the family was unable to afford it, and she stopped it about a year ago, but CARD is working on speech. She noted claimant did not speak in whole sentences and often left words out. He also misused tenses and pronouns, and spoke of himself in the third person. She felt claimant did not generalize pragmatic language and his teachers saw it as well as she did. As a result of his poor speech, claimant did not have any friends and did not play with other children, other than during organized play dates. She found claimant could not generalize play from the play dates, such as sharing, to unstructured play. She testified that other children noticed how poorly claimant spoke and would look at him funny or ask her to translate what he had said. She testified claimant’s teachers had mentioned this to her and was concerned about it.

In terms of receptive speech, claimant’s mother testified it was hard for claimant to understand subtle cues from others. For example, he did not get jokes. He did not play cooperatively with other children and did not talk to them except one child who had come to his house. Because of his deficits, claimant’s mother decided to enroll claimant in junior kindergarten.

In the area of self-care, claimant’s mother testified dressing was still a problem although he had made some progress. She described his ability to put on his shirt and underwear but he could not button or snap or zip or ties his shoes. She indicated claimant could perform some of these tasks with hand over hand prompts, but he did not do them by himself. When he put on clothes, he typically put them on backwards and his mother had to prompt him to put them on correctly. When he opens a drawer to get out clothes, the drawer

falls out. When claimant eats, he usually makes a mess by putting food partially in his mouth and the rest falling on his clothes. According to his mother, claimant does not use a knife, and when he gets a glass of water, typically spills some as he is filling the glass. After using a toilet, claimant had difficulty wiping his bottom, although when he is in therapy, he does so correctly. She worries about his toilet training abilities when he is in school.

Claimant's mother testified claimant generally had a difficult time with fine motor tasks. For example, his handwriting is virtually nonexistent, and despite working with him for more than a year, claimant could not write his whole name. Claimant's mother discovered that claimant learned his letters better when he could feel them, and is pursuing a sensory form of learning. She does not believe he has anywhere near the writing ability of a typical five-year-old child.

Claimant's mother described claimant's typical day. He was in school for three hours, but without an aide because the family did not have the funds to hire one. She would like to see him with an aide. Claimant receives three hours of CARD therapy a day as well, with one hour a week devoted to occupational therapy and another hour a week to vision therapy. She noticed that claimant becomes fatigued after a long day and therapists had to work harder with him when he was tired.

In the area of learning, claimant's mother testified it took claimant two years to learn numbers because of his visual input problems, and things only improved after a sensory approach was implemented. Because claimant has to concentrate so hard to learn, he fatigues easily and then becomes frustrated and he stops. He also loses his attention and fades out. She testified his working memory is poor and is a subject his teachers have worked on. She testified that claimant could not sequence three directions and imitate, so learning was difficult. She discovered that there were ten things children needed to know before they entered kindergarten, and she believed claimant could do four them: state his full name, know his phone number, know his birthday, and recognize and name the four basic shapes. She did not believe claimant could recognize and print his first name using capital and small letters, know traditional nursery rhymes, recognize and count one through ten out of sequence, count to 30, recognize upper case letters of the alphabet and lower case letters of the child's name, and locate the front and back of a book, point to a letter and a word, know where to start reading on a page, and understand reading is from left to right.

According to claimant's mother, the family has provided 1,500 hours of therapy through CARD, plus aides, and speech, occupational, and vision therapy in the last two years.

## LEGAL CONCLUSIONS

1. Under the Lanterman Act (Welf. & Inst. Code, §§ 4500 *et seq.*), the State of California accepts responsibility for persons with developmental disabilities and pays for the majority of the "treatment and habilitation services and supports" in order to enable such persons to live in the least restrictive environment possible (§ 4502, subd. (a)). The State

agency charged with implementing the Lanterman Act, the Department of Developmental Services (DDS) is authorized to contract with regional centers to provide developmentally disabled individuals with access to the services and supports best suited to them throughout their lifetime (§ 4520).

2. Welfare and Institutions Code section 4512 provides in part:

*(a) "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.*

...

*(l) "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:*

- (1) Self-care.*
- (2) Receptive and expressive language.*
- (3) Learning.*
- (4) Mobility.*
- (5) Self-direction.*
- (6) Capacity for independent living.*
- (7) Economic self-sufficiency.*

*Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.*

3. California Code of Regulations, title 17, section 54000, provides in part:

*(a) "Developmental Disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to*

*be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.*

*(b) The Developmental Disability shall:*

*(1) Originate before age eighteen;*

*(2) Be likely to continue indefinitely;*

*(3) Constitute a substantial disability for the individual as defined in the article.*

*(c) Developmental Disability shall not include handicapping conditions that are:*

*(1) Psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.*

*(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.*

*(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.*

4. California Code of Regulations, title 17, section 54001 provides

*(a) "Substantial disability" means:*

*(1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and*

*(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:*



- (A) Receptive and expressive language;*
- (B) Learning;*
- (C) Self-care;*
- (D) Mobility;*
- (E) Self-direction;*
- (F) Capacity for independent living;*
- (G) Economic self-sufficiency.*

*(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.*

*(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.*

*(d) Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.*

5. The voluminous record in this case contains numerous test results. Many of those tests are standardized tests. A dispute arose among the experts as to how the results should be viewed in terms of determining whether the score indicated a substantial disability. According to Dr. Cone, a score that was two or more standard deviations below average was necessary in order to find a substantial disability for the particular skill tested. Thus, on a test with a score of 100 indicating 50 percent of the population was above and 50 percent below, and one standard deviation consisting of 15 points, Dr. Cone believed only a score of 70 or below showed a substantial disability. Ms. Smith Roley testified one standard deviation or more showed a substantial disability. Dr. Perlman drew his line somewhere between the two but could not give a precise number. He testified that the range between 90 and 110 was average, but argued that to require a score of 70 or below was too limiting and would exclude 98 to 99 percent of the population from receiving regional center services.

It is common for psychologists to take into account variations in testing. For example, a score of 70 or below in a standardized IQ test generally is considered the threshold for finding mental retardation. However, Dr. Perlman testified a score of 75 could show mental retardation as well. Given testing differences and variations, that is a reasonable conclusion.

For purposes of determining substantial disability, where no numerical dividing line exists, consideration of testing variations and differences is helpful when considering a score between one and two standard deviations from the norm, that is, a score between 70 and 85. Using the five points Dr. Perlman used, it can be determined that a score of 75 or below would suggest a substantial disability, while a score of 80 and above would suggest that there was no substantial disability shown by that test. Accordingly, scores between 75 and 80 present the most difficulty in deciding whether the test points to substantial disability or not.

6. A preliminary matter arose as to whether the vision problems found by Dr. Ballinger could be considered in determining whether claimant is substantially disabled in three or more of the listed major life activities. Claimant's visual problems cannot be considered a symptom of autism and would not be addressed by regional center services. It would be logical to conclude that claimant's visual problems should not be considered in deciding whether he is substantially disabled. However, sections 4512 and 54001 of the Regulations contain no language to suggest a functional limitation has to be related to or constitute a symptom of the underlying developmental disability. The statute and regulation only require significant functional limitations in three or more of the listed major life activities. Thus, it must be concluded that a qualifying diagnosis coupled with evidence of any type of significant functional limitation is sufficient to find eligibility.

7. The issue in this case centers on one of the requirements set forth in section 4512 that must be met before claimant can be found to be suffering from a developmental disability and therefore eligible for services from the service agency – the disability must be substantial. The service agency does not contest the autism diagnosis. Accordingly, claimant must establish his disability is substantial and it can be expected to continue indefinitely in order for him to receive services under the Lanterman Act.

After all the reports and the testimony of all the witnesses have been considered, the conclusion is inescapable that the issue is one of degree. The service agency's experts believe claimant suffers from some disability, but not a substantial one, while claimant's experts believe the disability is substantial. Finally, claimant's experts concede claimant has made some progress over the years but that the disability will last indefinitely while the service agency's experts believe the progress he has made show his disability will not last indefinitely. One side points to all the things claimant can do; the other side points to the things he cannot do, or cannot do well. A review of all the evidence shows this is a very close and difficult case.

In reviewing the testimony and the reports of the various experts, due consideration is given to the training, background and experience of each in their respective fields. It must be noted that none of claimant's expert witnesses have had any significant experience dealing with eligibility of applicants for regional center services. On the hand, Dr. Cone and Dr. Parpal have worked for or consulted with regional centers for years and routinely consider whether applicants for regional center services meet the statutory criteria.

In addition, more consideration is given to later testing than to earlier testing.

When the Legislature amended section 4512 in 2003 to add subdivision (l), it greatly increased the level of disability a consumer must show before he or she can receive services from a regional center. In addition, the definition of substantial disability contained in section 54001 contains two parts: it requires a condition which results in major impairment of cognitive and/or social functioning, and the existence of significant functional limitations in three of the seven listed areas. To decide these issues, the evidence on each of the five major life activities relevant to this case must be considered separately:

a. Receptive and expressive language. A number of tests suggest claimant is not substantially disabled in this area, while a few suggest he is. Dr. Ito administered the Stanford-Binet test and claimant achieved a score of 96 on the verbal test. Dr. Bostani administered the WPPSI-III in 2006 and claimant achieved a verbal score of 102, with scores on the four subtests ranging from average to superior, while his processing speed was below average. His score on the TOPL was average at 108, while his score on the VABS-2 were generally moderately low, with receptive communication average and coping skills low. His score on communication was 85 and socialization was 81. The District administered the PLAI-2 and claimant scored in the average range (108), as was his score on the CASL testing pragmatic judgment (112). He was in the mildly delayed range in the Assessment of Phonological Processes-Revised but on the CELF-PS2, a checklist completed by claimant's mother, his score was well below the criterion for his age. Similarly, the CDI and SIB-R based on information from claimant's mother placed claimant's development as substantially disabled. However, on the SIB-R reported by claimant's preschool teacher, claimant's score was average age-appropriate.

Ms. Hein's scores require some analysis. On the CELF-P she administered in 2004 when claimant was three years old, claimant's language score was 97 and his age equivalent was three years. The results of the same test administered in 2006 were similar (100). Likewise, Ms. Almeida found in 2004 that claimant's expressive language skills were age-appropriate, with mild characteristics of motor planning difficulties and oral motor tasks. Ms. Hein's testimony that the criterion cutoff subtests which show claimant does not meet age criteria detract from the significance of the standard scores is rejected. More weight should be given to the standard scores than the criterion scores.

On balance, the weight of the psychometric testing, particularly the objective, standardized testing, does not show claimant is significantly functionally limited in the area of language. At most, the testing established mild delays in language. That is consistent with Ms. Hein's observation in her 2004 report that claimant presented with a varied profile of language skills, with age-appropriate receptive and expressive language skills but with weaknesses in some areas. Her view was claimant had a mild to moderate expressive language disorder and was at risk for a receptive language disorder. In addition, she believed claimant's prognosis was excellent for increasing his language skills, and she found greatly improved skills in 2006. Her observations that the weaknesses in his performance contained "red flags" for future difficulties suggest those weaknesses are not that significant currently, but might in the future pose functional problems. However, determination of claimant's eligibility for regional center services must be based on his current functioning, not anticipated problems that may or may not arise.

Evidence describing claimant's abilities in language that are not based on testing is varied. Claimant's mother paints a bleak picture of claimant's abilities. On the other hand, Dr. Cone reported from his observation of claimant at home and at school that claimant generally interacted appropriately with peers, his teacher, and other adults. Ms. Thompson's observation did not reveal any significant disabilities in language. Dr. Bostani observed claimant at school on May 17, 2006 and reported claimant demonstrated appropriate eye contact, responded to group questions appropriately, and maintained focus towards his teacher during circle time. Her observation did not reveal a substantial disability in language. However, Dr. Ballinger's description of claimant's language abilities showed a significant disability in language. Dr. Donnelly's reports, particularly his latest one in 2006, showed claimant had made progress, but had weaknesses. He indicated there might be an evolving learning disability or even a mild attention deficit hyperactivity disorder. In light of his view of claimant's autistic spectrum disorder as mild, his reports of weaknesses cannot be construed to indicate a belief on his part that claimant's abilities are significantly disabled.

Based on all of the evidence relating to claimant's expressive and receptive language, and in particular objective test results and the testimony and opinions of Dr. Cone and Dr. Parpal, it must be concluded that the evidence did not establish a significant functional limitation in claimant's receptive and expressive language.

b. Learning. Claimant's IQ as measured by the WPPSI-R by Dr. Bostani and the Stanford-Binet by Dr. Ito were average. His score on the Bayleys Scales of Infant Development-II administered by the District when he was three years of age was within normal limits as were the KABC-II, TAPS-R, and Woodcock-Johnson Test of Achievement administered by the District in 2006. His scores on the Leiter-R administered by Dr. Bostani in 2004 and 2006 were average except for forward memory which was low. His score on the VMI administered by Dr. Ito was 80 which she interpreted to show a "possible weakness" and in the low average range. These scores clearly show claimant has the potential to perform at age appropriate levels.

However, Dr. Ito also considered the ABAS-II completed by claimant's mother that placed claimant in the mildly to moderately delayed ranges. In her view there were several factors which appeared to interfere with claimant reaching his potential, including his significant attention issues, his seeking out of sensory input, his motor planning issues, and his visual perceptual skills. She recognized his cognitive strength and could not say if his delays in current functioning were suggestive of a life long disability.

Dr. Ballinger likewise found differences between claimant's test scores and the way he handled situations which arose in his life. She pointed out, for example, that despite relatively high scores in language, when he spoke, he used one to three word sentences, omitted words, and gestured. He also took a long time to make judgments and complete tasks. She also noted that on some days, claimant performed better than on other days.

It appears from claimant's mother's testimony that she and the CARD therapists are learning how claimant learns. They have experimented with other methods than a simply visual approach and they have been achieving some success. As Dr. Perlman said, children with autism are "quirky" and they may learn differently.

Despite the many weaknesses and deficits identified by claimant's mother, Dr. Ito, and Dr. Ballinger, claimant's standardized test scores coupled with the testimony and reasoning of Dr. Cone and Dr. Parpal compel the conclusion that claimant does not have a significant functional limitation in the area of learning.

c. Self-care. Most of the testing placed claimant in the significantly impaired range. Claimant's general adaptive composite score on the ABAS-II administered by Dr. Ito was 57 and his scaled scores on self-care and home-living were 2 (the average is 8-12). The CDI in self-help and SIB-R in personal living and community living administered by the District in 2006 were very low. Claimant's performance on the VABS—Daily Living administered by Dr. Bostani in 2004 and 2006 were 72 and 71, respectively. It is only the SIB-R reported by claimant's preschool teacher to the District in 2006 which placed claimant at an age-appropriate level.

Claimant's scores on many fine motor tests showed significant difficulties, and those difficulties impacted his ability to perform many self-care tasks. Claimant has difficulty holding a pencil or crayon and thus has difficulty writing letters or coloring. He has difficulty buttoning, zipping, fastening, and so forth. He has difficulty holding spoons, forks, and knives, and is described as a messy eater. Claimant's mother's testimony, supported by the testing in self-care and fine motor tasks, established claimant had significant functional limitations in the area of self-care.

d. Mobility. There are no tests upon which to rely to judge claimant's ability in this area. Indeed, there is nothing in the statute or regulation to suggest what motor skills are to be considered. The service agency takes the position that if the evidence showed claimant could move from one place to another, without assistance, that was sufficient to establish there was no significant functional limitation. Claimant argued that cerebral palsy was a separate qualifying condition, and therefore an applicant for regional center services with a diagnosis of autism did not need to establish that degree of limitation in order to be found to have a significant functional limitation in the area of mobility. While clearly claimant was not required to establish he suffered from cerebral palsy as well as autism in order to establish regional center eligibility, he did have to establish a significant functional limitation.

The evidence established claimant could walk, run, climb stairs, play on a trampoline, play soccer, and play with others on a playground. There was no evidence that he needed assistance to perform these tasks or that he routinely suffered injuries when playing, walking, climbing stairs, or running. His mother described minor injuries that could be sustained by any five-year old boy. The tests of his gross motor abilities showed he was clumsy and had poor motor planning ability. Nevertheless, claimant's deficits in those areas do not establish a significant functional limitation in the area of mobility. This conclusion is supported by the opinions of Dr. Parpal and Dr. Cone.

e. Self-direction. Claimant's scores on testing by Dr. Bostani, the District, and Dr. Ito showed significant limitations. The testimony describing his activities in school and at home are contradictory, but greater weight is given to his mother's testimony since she has had a far greater opportunity to see how he performs his assigned tasks than

others who have seen him only once or twice. Based on the testing and claimant's mother's testimony, claimant established a significant functional limitation in the area of self-direction.

f. Summary. Sections 4512 and 54001 of the Regulations require significant functional limitations in three of the seven listed areas. Because claimant is a child, the areas of capacity for independent living and economic self-sufficiency are not relevant. Claimant was only able to establish significant functional limitations in two areas, not three. He therefore did not establish he suffered from a substantial disability.

g. Major impairment. Section 54001 of the Regulations contains a requirement for establishing a substantial disability not contained in section 4512: that the condition results in a major impairment of cognitive and/or social functioning sufficient to require interdisciplinary planning and coordination of services.

Dr. Bostani was the first professional to diagnose claimant with autistic disorder, but her diagnosis, as well as subsequent ones, all placed claimant in the mild range. That coupled with scores on such tests as the Stanford-Binet, WPPSI-R, and others, showed no major impairment in the area of cognitive functioning. Claimant's social functioning, however, is more problematic. Nevertheless, given the mild nature of his underlying developmental disability, it cannot be concluded that he suffers from a major impairment in social functioning.

h. Indefinite continuation of disability. Since claimant is not eligible for regional center services because he did not establish a substantial disability, it is unnecessary to further determine if his condition would be expected to continue indefinitely.

## ORDER

The decision of the service agency which determined claimant is not eligible for regional center services because he does not suffer from a substantial disability is affirmed.

## NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.

DATED: \_\_\_\_\_

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ALAN S. METH  
Administrative Law Judge  
Office of Administrative Hearings